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ROYAL COMMISSION
ON
HEALTH SERVICES



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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

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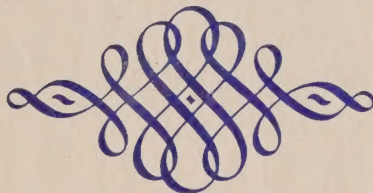
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VOLUME 3

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings
held in Toronto, Ontario,
on the 30th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL, -- Chairman

Miss ALICE GIRARD, R.N.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

Mr. M. WALLACE McCUTCHEON, Q.C.

Prof. O.J. FIRESTONE

Dr. DAVID M. BALTZAN

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

COMMISSION SECRETARY:

Mr. N. LAFRANCE



We intend, 30th May, 1962.

On commencing at 9.30 a.m.

THE CHAIRMAN: Mr. Chairman, the

first submission this morning is that of the Ontario
Public Health Association, which will be Exhibit No.
14, and Dr. Sturgeon will speak to the public.

--- EXHIBIT NO. 14 --- Submission of the Ontario Public
Health Association.

PRESENTATION BY THE ONTARIO HEALTH

Mr. John Robson
Miss Margaret Gibson
Dr. A. C. Fleming
Dr. A. E. Hall

THE CHAIRMAN: Dr. Sturgeon, please.

DR. STURGEON: Mr. Chairman and

members of the Commission: I would first like to call

on Mr. John Robson, President of the Ontario Public

Health Association, to introduce the rest of the members

MR. ROBSON: Ladies and gentlemen:

Miss Margaret Gibson, on this side here is our second

Vice-President, Miss Gloria King represents Public

Health Education; Dr. Sturgeon is a Medical Officer of

Health, and also the author of the paper; Dr. Fleming

represents Veterinary Public Health; and Dr. Hall

represents the Medical Officer of Health.

MR. STURGEON: You have a copy of the

list. The presentation can be taken as read. With



Sturgeon

11876

your permission I will deal with the recommendations and the summary.

THE CHAIRMAN: And if you want to interpolate any explanations or observations as you go along it is quite helpful.

DR. STURGEON: Thank you. You will notice, Mr. Chairman and members of the Commission, as an Association representative of many disciplines, this presentation follows very closely the items that you were asked to investigate as contained in the Order in Council.

The existing facilities and methods for the provision of personal health services.

The existing facilities and methods of providing public health services for the people of the Province of Ontario have been outlined. This information applies essentially to those services furnished by Boards of Health in 13 cities and 34 Health Units.

I might point out at this time that in the brief there is information about 35, but one of them was formed during the middle of 1961, and therefore, some of the statistics are not available. Since that time, I might point out, that two other health units, I think, are in the process of formation.

It is estimated that 82% of the population is rendered public health services by these Health Departments. For the remaining 18% of the population, insufficient information is available to make any specific statements.



1976

Sturgeon

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Sturgeon: 11877

Methods of improving existing health services.

It is recommended that the remaining 18% of the population of the Province come under the administration of full-time, properly qualified personnel with a Health Unit type of administration.

Correlation of new or improved programs with existing services with a view to providing improved health services.

Enough experience has been acquired since 1945 in the operation of Health Units to extend these operations with very little difficulty or dislocation of personnel. The 18% of the population not being rendered service by full-time, fully qualified personnel could have these services made available by the creation of additional Health Units or the extension of existing ones.

Future requirements of personnel to provide health services.

The numbers of public health nurses and sanitary inspectors are barely minimal to staff existing Health Departments. There is a deficiency of 10 qualified health officers and deficiencies exist in dentists, veterinarians and health education consultants with post-graduate public health training. It is recommended that these needs must be met as speedily as possible and provision be made to supply for future population expansion - one health officer for a population of 25,000 minimum and 60,000 maximum.

These minimums and maximums refer to ideal, and those numbers that are needed to carry on



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Sturgeon

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the program of a basic character.

One public health nurse for each 3,500 population minimum and 5,000 maximum; one sanitary inspector for 12,000 population minimum and 18,000 maximum; one dentist for each 200,000 population assisted by a minimum of 3 dental hygienists for each dentist (preferably one for each 8,000 elementary school children; that refers to the hygienists); one veterinarian for each 50,000 population minimum and 100,000 maximum; one health education consultant for each 75,000 population minimum and 100,000 maximum; one nutritionist for each 300,000 population minimum and 500,000 maximum. Additional full or part-time auxiliary or ancillary personnel may be employed as required. That refers, of course, to those having secretarial training. It is desirable that all of these persons should have post-graduate training in Public Health.

Methods of providing adequate personnel with the best possible training and qualifications for such services.

Post-graduate public health training for doctors, dentists, veterinarians, health education consultants, nutritionists and other personnel is provided by the University of Toronto in this Province. Undergraduate or post-graduate training for public health nurses is available at universities located in Windsor, London, Hamilton, Toronto, Kingston and Ottawa. Certain refresher courses are provided by these universities. However, there is a distinct lack of opportunity for public health personnel to upgrade their



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Sturgeon

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qualifications by extension or summer courses, despite the fact that a few employed in or near some University centres may avail themselves of courses in the liberal Arts.

It is recommended that the facilities which have been used extensively and successfully by members of the teaching profession should be made available for public health personnel as well. That refers essentially to methods. In other words, a large number of educators holding responsible positions, administrative and otherwise, have stated to me personally that they commenced their teaching experience in a one-room school in the country with a second-class professional certificate, and through the availability of summer courses and extension courses, they have been able to upgrade their qualifications. There is no inference that you should not have anything less than basic qualifications to start with.

The Sanitary Inspectors' Training Course sponsored by the Ontario Department of Health in co-operation with the Department of Education using the facilities in part of Ryerson Institute, has been most successful in the training of personnel. These facilities should be extended, as it has been recommended, for other personnel above to provide extension and summer courses. I might just add here that it is my personal impression - I don't know whether the other members agree with me - that any type of training should lead and be given credit for essentially and finally a degree type, if possible by university.

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Sturgeon

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The present physical facilities and the future requirements for the provision of adequate health services.

City Health Departments and Health Units should participate more fully in the Federal Hospital Construction Grant so as to provide accommodation for community health services in keeping with those presently provided for active treatment, convalescent and chronic hospitals.

The estimated cost of health services now being rendered to Canadians with projected costs of any changes that may be recommended for the extension of existing programs or for any new programs suggested.

The estimated cost of health services in 13 cities and 34 Health Units are included in this presentation as an appendix. No information can be furnished for the cost of providing health services for the remaining 18% of the population.

THE CHAIRMAN: I suppose you could do it on a per capita basis?

DR. STURGEON: It would only be an estimate, sir, because the information is not available to the Department of Health.

The funds used by Boards of Health to render these services are obtained from three main sources, namely, Municipal, Provincial and Federal.

Estimates of the amounts of monies spent per capita have been stated.

It is recommended that Health Units should participate financially in all Federal Health Grants designated for hospital construction, mental



11880

Sturgeon

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Sturgeon

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health, tuberculosis control, public health research, general public health, cancer control, medical rehabilitation, and child and maternal health, because Boards of Health are involved in expenditures relating to these basic programs. Federal Health Grants are estimated (Wride, G.E. - J.C.P.H.A. 1961, 52:91) as amounting to \$2.11 per capita. It seems reasonable to suggest that \$1.25 of this amount be made available for basic public health programs rendered by Boards of Health in 13 cities and 35 Health Units of the Province. The principle of Provincial matching grants ranging from 25 to 50 percent of the cost of operating these Health Units is well established and has been accepted by all concerned. Municipalities now provide an amount of money on the average exceeding \$1.00 per capita; that is shown in the appendix. This should not be reduced and there is little indication of a desire to do so by the various Municipalities served. The inference there is that the Municipalities have had for years a very definite responsibility to provide health services. This has been accepted, and it is not a case of reducing their expenditure by the use of either provincial or federal health grants, but rather that that be added to it.

It is estimated that with a minimum of \$2.25 per capita per year, Boards of Health could reimburse their employees in keeping with salary schedules or income earned by other members of the professions or vocations possessing a similar level of basic and post-graduate education.



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Sturgeon

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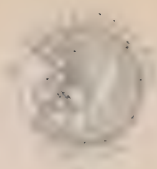
This Association recommends that pensions should be portable, and I think that the present legislation in the Province has made that possible, and should be comparable to those enjoyed by Public Health personnel employed by the Provincial Department of Health.

In the case of city Boards of Health, it is recommended that these should participate in Provincial Health Grants to the same extent as do Boards of Health for Health Units. At the moment city Boards of Health do not participate in provincial matching grants. The reason, I think, has been attributed to the fact that there are other grants made to cities, which vary in size. Larger grants are made to larger cities, unconditional grants. However, we feel that unless monies are earmarked for a specific purpose, they may be channelled into other areas.

The methods of financing health care services as presently sponsored by management, labour, professional associations, insurance companies or in any other manner.

This Association appreciates the value of prepaid sickness care programs and recognizes that these should be available to the total population. However, we regret that provision is not made by all of them to pay for preventive services. We recommend that this be an essential part of any insurance type of plan.

This Association recognizes the principle that the method of payment for services rendered must be decided and be agreed to by both those



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Sturgeon

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supplying the service and those who are the recipients.
The methods of financing any new or extended programs
which may be recommended.

This Association is aware that a percentage of the population can be classified as being medically indigent and society in general must recognize this fact, therefore, any premiums must be related to the recipient's ability to pay these.

It is appreciated that an indemnity type of payment to those providing treatment services would cause less objection than a service type of remuneration. Quite frankly, that is based on the Australian experience.

The relationship with existing and any recommended health care programs with medical research and the means of encouraging a high rate of scientific development in the field of medicine in Canada.

Health Departments should have reasonable opportunities to engage in public health research. This would apply particularly to program change or development and the best use and deployment of existing personnel. Health Departments, therefore, should be eligible for Federal Health Grants in particular the public health research portion of these.



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Sturgeon

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3
4 The feasibility and desirability of priorities
5 in the development of health care services.

6 27. It is recommended that priority must
7 be given to the problems of infant mortality and maternal
8 deaths (Department of Health - Ontario. Presentations
9 by Ontario Department of Health Staff Area Conferences
10 1962. Maternal and Child Health - 1,2 and 3.)

11 The rates for these in this Province
12 are not in keeping with those in other areas of the
13 civilized world which have a similar standard of
14 living.

15 28. Bradley Buell, as a result of a study
16 in Minneapolis-St. Paul, has stated that "hard core
17 families comprise between 5% and 6% of the total
18 population and account for one half of all juvenile
19 delinquency and use between 60% and 80% of Health and
20 Welfare Services."

21 This study made in a larger urban
22 centre may not be entirely applicable to the total
23 population of this Province, however, Public Health
24 workers are aware and recognize the complex problems
25 created by these families and all municipalities and
26 appreciate that while the overall total may be less, the
27 same relative percentage of health and welfare
28 complications develop.

29 29. It is recommended that every effort
30 be made to improve and accelerate the programs of
Official Social Welfare Agencies in an endeavour to
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The feasibility and desirability of priorities

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Sturgeon

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care and treatment if those receiving it return to homes, and it could be added, that are disintegrating. 30. It is recommended that the fluoridation of communal water supplies be accelerated by a program of vigorous health education in accordance with the recommendations and findings of those who have investigated the benefits to be derived therefrom (Brown H.K., McLaren H.R., Josie G.H. and Stewart R.J. The Brantford-Sarnia-Stratford Fluoridation Caries Study 1955 Report Canadian Journal Public Health 47:149, 1956.) (Report of the Committee appointed to inquire into and report upon the Fluoridation of Municipal Water Supplies 1960. P.O. 120-122)

31. This Association recognizes fully that while public health programs may change because of public need, very few can be discontinued or eliminated, although the emphasis may vary with changing social and economic conditions.

32. Finally, it is recommended that measures be taken to increase the number of qualified personnel to provide services related to the prevention and treatment of mental illness and the promotion of mental health. These services are now inadequate.

In summary, therefore, the Ontario Public Health Association includes in its membership various professional and vocational groups. The majority of these members are employed and carry out their duties in official health agencies. The variety of professional and vocational groups represented in the Association demonstrates that Public Health Services are complex and



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1
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3
4 require the services of these various professional and
5 vocational personnel to be completely effective.

6 2. ~~Related to the topic~~ Recommendations have been made for
7 the improvement of Public Health Services in the Province.

8 These are related to the provision of full-time services
9 employing properly qualified personnel for the total
10 population. This emphasizes the statement that "a
11 public health program adapted to the individual needs
12 of each area offers the most economical means of breaking
13 the chains of disease and poverty and initiating
14 an upward cycle of social evolution." (Winslow, C.E.A.
15 "The Cost of Sickness and the Price of Health". WHO
16 Monograph, 1951.)

17 3. ~~Then it is discussed~~ The principle that the cost of
18 supplying Public Health Services should be borne by the
19 three levels of Government is discussed. This does not
20 entail any large additional outlay of funds but rather
21 relates to an equitable distribution of the expenditure
22 between the three levels of Government based on existing
23 and projected costs and amount of funds available.

24 4. ~~Some suggestions are made~~ All professional groups are too few
25 in number. Suggested methods of improving this
26 situation are outlined in so far as they relate to
27 training, development and remuneration.

28 5. ~~Concluding remarks~~ The need for Public Health research
29 is indicated. This applies to the necessity of program
30 change and development. Emphasis is placed on the
principle that Public Health activities include the
complete spectrum extending from prevention to
rehabilitation.

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public health program adapted to the individual needs

of each area offers the most economical means of breaking

the chains of disease and poverty and initiating

an upward cycle of social evolution." (Whitlow, C.E.A.

"The Cost of Sickness and the Price of Health". WHO

Monograph, 1951.)

3. The principle that the cost of

supplying Public Health Services should be borne by the

three levels of Government is discussed. This does not

entail any large additional outlay of funds but rather

relates to an equitable distribution of the expenditure

between the three levels of Government based on existing

and projected costs and amount of funds available.

4. All professional groups are too few

in number. Suggested methods of improving this

situation are outlined in so far as they relate to

training, development and remuneration.

5. The need for Public Health research

is indicated. This applies to the necessity of program

change and development. Emphasis is placed on the

principle that Public Health activities include the

complete spectrum extending from prevention to

rehabilitation.



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6. Priorities have been recommended for desirable program development or extension as they relate to the total problem of health needs.

THE CHAIRMAN: Thank you, Dr. Sturgeon.

COMMISSIONER VAN WART: Dr. Sturgeon, in section 7 you speak about the Boards of Health in 13 cities and 34 Health Units. Would you give me some information on how the personnel of these units, health units, are appointed?

DR. STURGEON: Well, whether it be a city or whether it is a health unit, they all have to have boards of health, that is the official agency, and any personnel is appointed by the Board of Health, either by advertising for them, applications, interviews, and so on.

COMMISSIONER VAN WART: That is the local ---

DR. STURGEON: Local Board of Health.

COMMISSIONER VAN WART: Is there any stipulation in the law that so many shall be medical men and so many lay men, plumbers and engineers?

DR. STURGEON: No. The only stipulation is contained in part of the brief, number 36, which is quoting directly from the Act, that "Each municipality in Ontario, except where a Health Unit is established, shall have a local Board of Health." And 37, that "The Council of every Municipality shall appoint a legally qualified medical practitioner to be Medical Officer of Health for the Municipality and shall also appoint such number of Sanitary Inspectors for the Municipality as

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4 may be deemed necessary by the local Board." These are
5 the only mandatory statements in that Act. To continue:
6 "A Board of Health, therefore, may function on behalf of
7 a Municipality or for a Health Unit. A Health Unit is
8 usually established on a County basis serving cities,
9 towns, separated towns, villages and townships located
10 within the County borders". These are the only mandatory
11 appointments, but in the Public Health Act it states
12 that a Board of Health may employ other personnel, and
13 except in these areas not covered by cities or the Health
14 Units, even those employ many other personnel, and it
15 is principally public health nurses.

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17 COMMISSIONER VAN WART: What is their
18 tie-in with the Department of Public Health?

19 DR. STURGEON: At the provincial level?

20
21 COMMISSIONER VAN WART: Yes.

22
23 DR. STURGEON: Well, the provincial
24 department acts in a supervisory capacity. It is a very
25 good relationship in this province, I think it is one
26 of the best, where Boards of Health are autonomous, and
27 while there are regulations governing the formation of
28 Health Units, in general local autonomy is supreme, and
29 that has led to a good situation, I would say, in this
30 province.

COMMISSIONER VAN WART: Does that
legally qualified medical person have to have post-
graduate study in public health?

DR. STURGEON: Not in all municipalities,
but in cities he can act as a medical officer of health
outside of the cities or larger centres.



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4 COMMISSIONER VAN WART: How are these
5 Health Units formed? What is the procedure in forming
6 the Health Unit?

7 DR. STURGEON: Well, it is stated here,
8 Doctor, these are usually on a county basis. They don't
9 have to be, but any group of municipalities or any
10 municipality and school board can combine to form a
11 unit. It has to be more than one municipality; it
12 refers to more than one municipality.

13 COMMISSIONER VAN WART: Does the
14 direction come from the provincial Board of Health or
15 is it a spontaneous thing?

16 DR. STURGEON: The Provincial Board
17 of Health usually does, on invitation, go and explained
18 the activities of Health Units to county councils in
19 general, and it is necessary that the county council or
20 the municipalities involved, if it is less than that of
21 county, to pass a by-law establishing the Health Unit
22 according to the regulations under the Public Health
23 Act.

24 COMMISSIONER VAN WART: That gives me
25 a fairly good picture.

26 Now, paragraph 10, you speak of
27 deficiencies in public health nurses, sanitary inspectors,
28 and so on. Is there any reason for that deficiency?

29 DR. STURGEON: Well, I would say, to a
30 fundamentally maybe the rates of pay. They are grossly
underpaid, all of these personnel, compared with other
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7 can receive despite the fact that he has to have a n 11,
8 certain level of secondary school education, at least
9 Grade XII, and take a one-year, academic year course to
10 be qualified at present. So that to me is the funda-
11 mental cause of the deficiency there.

12 As far as nursing staff is concerned,
13 of course, nurses are in short supply every place,
14 hospitals and every other type of nursing, and again it
15 is related to, I would say, fundamentally the salary
16 schedules.

17 COMMISSIONER VAN WART: In other words,
18 the people are not going into the profession.

19 DR. STURGEON: No.

20 COMMISSIONER VAN WART: On account of
21 economic conditions?

22 DR. STURGEON: That is right.

23 COMMISSIONER STRACHAN: Do the Public
24 Health personnel work under a pension system?

25 DR. STURGEON: Most of the departments
26 now, not all. I wouldn't want to be dogmatic, but most
27 of them, not necessarily all of them, until the recent
28 legislation which was passed which states that after a
29 certain time all municipalities and boards will have a
30 portable pension of a type.

COMMISSIONER STRACHAN: It will be
portable within the province?

DR. STURGEON: Yes. I think we were



can speak to that. I am in charge of a Health Unit in an area where the rates of pay for someone with much less education in industry is greater than what sanitarians can receive despite the fact that he has to have a certain level of secondary school education, at least Grade XII, and take a one-year, academic year course to be qualified at present. So that to me is the fundamental cause of the deficiency there.

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3 told yesterday it will be portable within the province,
4 but that doesn't mean that at certain national levels
5 it will not be portable outside the province.

6 COMMISSIONER VAN WART: In section 11,
7 about half-way down, you state there is a distinct lack
8 of opportunity for public health personnel to upgrade
9 their qualifications, et cetera. Would you enlarge a
10 little on that?

11 DR. STURGEON: I would be glad to,
12 sir, and I think some of the other members can here;
13 perhaps the two ladies on my right may be prepared to
14 speak further.

15 The difficulty is that except in
16 the larger centres -- and I am speaking specifically now
17 of persons with the first level that is referred to of
18 post-graduate education in Public Health -- thereafter
19 it is very difficult for them in contrast, and I mentioned
20 the education field particularly, to get additional
21 courses; for example, to go on to a degree by extension
22 or summer courses.

23 I happen to have on my own staff one
24 of the nursing members who is taking her month's holidays
25 and leave of absence for another month to take the
26 course in liberal arts summer school. I think this
27 reference here, of course, refers to possible courses
28 she may take in nursing, in administration or teaching
29 or some of the other types of post-graduate education
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That is in contrast to the people they work with very closely in an educational system who can do it and, as a result, profit financially. Perhaps Miss King or Miss Cahoon could go further.

MISS CAHOON: I think as Dr. Sturgeon has intimated there are possibilities for people to do this within the same type of courses that are available now for teachers, but in things that are more strictly related to public health there has not been very much opportunity for this. I think probably you are aware the school of hygiene is planning to plan toward a more continuing education program and with this in mind we have been running refresher courses in the Wintertime at the school of hygiene in the last few years. However, there is a feeling that that needs to be decentralized, so it is not so expensive for the average staff member to attend. Just a limited few that can come from other parts of Canada can attend. This was announced yesterday morning, as Dr. Sturgeon knows, to our graduates that this plan is being developed.

I think that this whole area of continuing education is one that is receiving attention in a great many areas at the present time in Canada and is likely to get a great deal more.

COMMISSIONER VAN WART: Is the difficulty in getting a leave of absence from a health unit to take these courses, to get replacements and so on?

DR. STURGEON: Well, there is a minimal amount of staff and it presents certain difficulties. The only way, speaking personally, the only way

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members of my staff can get a certain basic or liberal arts course is on Saturdays or they can drive forty miles and return to take night courses at the University in Hamilton. It is difficult to give leave of absence in contrast to the teaching profession who have two months holidays in the Summer. We can arrange, I think, possibly if more courses are available we would arrange as I am going to do this year.

THE CHAIRMAN: Summer courses of what, six weeks?

DR. STURGEON: Six weeks. Miss King is Health Education Consultant to a voluntary agency and if my memory serves me right, she has had teachers' training, and also public health, so she should be able to speak to this better than most of us.

MISS KING: In the field of health education, health education as a profession in Canada is relatively new, about ten years and to receive post-graduate training in Canada there is a certificate course at the school of hygiene and a one-year course at the University of Toronto. If you wish a Master's degree you attend two years. Now, just to the south of us is the University of Michigan which gives a Master's in public health in one year. We are finding it very difficult in having students trained, those who wish to stay in Canada for one year for a certificate rather than go to Michigan for one year for a Master's degree. It is a particular problem in health education at the moment.

MR. ROBSON: I would like to comment on behalf of the sanitary inspectors or public health



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MR. JOHNSON: I would like to comment

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inspectors. We have had the formal course for a number of years and many of us in the field feel that basically it is much too short a time in which to qualify a man properly for the job he has to do. However, this is among the newer happenings in the Province, the establishment of a formal course of training. We hope that formal course will be extended. We would hope to see our people taken in as students to a health agency with adequate facilities for training and for a period of possibly two years and then be taken to a recognized educational institute for their formal training. We would also like to see, in fact, we have instigated this on our own, post-graduate courses on a yearly basis in order to keep up with the advancing technology in our particular field. It is a complex field, environmental sanitation and advances in chemicals, agriculture, industrial toxicology, the wide field of food preservation and that type of thing, we find it quite difficult to keep up to date, so that we as a group are very interested in trying to keep abreast of modern developments.

COMMISSIONER VAN WART: Does your group have difficulty in getting away for post-graduate training?

MR. ROBSON: At the moment we have not had much difficulty, because our courses have been short; the most extensive course we have had here only lasted four days. We would like to see a proper seminar, two weeks, to work here and I doubt if we would have much difficulty providing we had the backing of the Provincial Department, the local Department of Health and the Board of Health. There may be difficulty, I can anticipate



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difficulty for junior staff members because we cannot take them all at once. In a health unit where they have four inspectors you could not possibly do that, the course would have to be extended so as to allow two going or one going and that type of thing, so that you would have coverage. It is much easier for senior personnel to go to such a thing, but we feel, of course, that both junior and senior personnel require that type of training.

DR. FLEMING: In veterinary public health there is a diploma course of one year at the school of hygiene. Once again, if you want a Master's you must go to the States or at least the men who get a Master's go to the States. Further than that the refresher course that Miss Cahoon spoke of, usually one day is slanted, so that veterinaries can get in on that, it is usually in combination with the medical profession.

THE CHAIRMAN: As I listen to this discussion, not taking any adverse view of post-graduate education, but is it necessary that, by and large, everybody should have a Master's degree for the carrying out of the routine work of public health through the Province?

DR. STURGEON: Dr. Bull.

THE CHAIRMAN: I just put it as crudely as I could.

MR. ROBSON: From my point of view the training problem, we are taking people and there is no problem.

THE CHAIRMAN: I can understand it in the teaching aspect in certain positions, particularly in the post-graduate teaching field itself you must have



difficulty for junior staff members because we cannot take them all at once. In a limited sense where they have their inspectors you could not possibly do that, the number would have to be extended so as to allow two going on one going and that sort of thing, so that we would have coverage. It is much easier for senior personnel to go to such a thing, but we feel, of course, that both junior and senior personnel require that type of training.

DR. THURMOND: In veterinary medicine health there is a diploma course of one year at the school of hygiene. Once again, if you want a doctor's you must go to the States or at least the man who got a doctor's to the States. Further than that the physician course and this school of hygiene, usually one day is a school so that veterinarians can get in on that it is usually in combination with the medical profession.

THE CHAIRMAN: As I listen to this discussion, not making any adverse view of post-graduate education, but as it necessary that, by and large, everybody should have a doctor's degree for the carrying out of the routine work of public health that is the function of the medical profession.

DR. ROSS: Now my point is that the training program, we are talking about, seems to me to be a post-graduate training program, and we are talking about a post-graduate training program.

THE CHAIRMAN: I am not sure if the training aspect in certain positions, particularly in the post-graduate training there itself, you have some



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properly qualified people teach at the basic level. However, are you getting to a point where we are talking about post-graduate levels merely as a status and not by way of necessity?

MR. ROBSON: In our case, returning to my particular point of view, we feel it is an absolute necessity. We are not trying to acquire something although I agree with Dr. Sturgeon in that we should receive some recognition for the work done on this additional learning and training we are doing. We feel it is an absolute necessity. We are not trying to acquire any degree, we feel we must do it.

THE CHAIRMAN: You are trying to obtain a degree.

MR. ROBSON: We are not worrying about that.

THE CHAIRMAN: That is your position, to attain the first level.

MR. ROBSON: Yes, and after all, we find it is absolutely essential in order to keep abreast of the new developments in our field to take this continuing education.

MISS KING: Health education is basically a post-graduate type of work. We are interested ----

THE CHAIRMAN: I am conceding that, that is your basic proposition.

MISS KING: That is right and basically we are not out for a degree for a degree's sake. We are out after the skills that are required and the knowledge obtained from going through the process of getting such

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King 10. 11897

a degree. It is also an advantage when you are working with degree people who also have a degree.

COMMISSIONER BALTZAN: Is there something going in that direction in relation to requirements of departments or boards that the salaries are based on the kind of academic standing rather than the amount of experience in the field? Is that one of the reasons for this general desire to not only improve by post-graduate work, but to obtain a level for the work done?

DR. STURGEON: Speaking personally, I have my certification of the Royal College of Physicians and Surgeons and also the American Board of Preventive Medicine, and I have not noticed myself being paid more because of that. However, it is desirable, in my work where I work in an area, for instance, where half of the medical practitioners have their certification, I think it does add something, at least it gives me a little more feeling of self-protection if nothing else. But, I do not think fundamentally, Mr. Chairman, that that is the idea. I do not think anyone is striving for a degree for the sake of the benefits it might provide. Certainly I think it indicates a little motivation and we look for that in our employees.

COMMISSIONER BALTZAN: I am not questioning but I do remember seeing a scene posted here and there that certain personnel belonging to the Department of Public Health and it states that a baccalaureate degree will start at so much money, so many thousands per and those who have had less than that will start at so much and the basis seems to be on the kind of qualification or recognition.



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COMMISSIONER SALINGER: I am not

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DR. STURGEON: It may be in some instances there is recognition of a degree. That applies in the field of nursing in the recommendations given us.

THE CHAIRMAN: There does not appear to be any good reason against it.

DR. STURGEON: No.

THE CHAIRMAN: Well, thank you very much, I just wanted to see what your reaction was to that.

COMMISSIONER VAN WART: Turning now to Paragraph 22, the concluding sentence you say that you recommend that this be an essential part of any insurance type of plan and that is a prepaid sickness care. Do you feel that public health should be incorporated in any plan that may be evolved, not like in the old country where public health is not part of the national health insurance scheme at all, it is separate and distinct and you feel it should be tied in?

MR. STURGEON: It may be a little

instances there is recognition of a failure. That applies in the field of nursing in the recommendations given us.

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MR. STURGEON: No.

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COMMISSIONER VAN WART: Turning now to

Paragraph 22, the concluding sentence you say that you

recommend that this be an essential part of any insurance

type of plan and that is a prepaid sickness cover. Do

you feel that public health should be incorporated in any

plan that may be evolved, not like in the old country

where public health is not part of the national health

insurance scheme at all, it is separate and distinct and

you feel it should be tied in?



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4 DR. STURGEON: The suggestion sir is
5 that preventive services -- as you are aware, all
6 medical practitioners practise preventive medicine. We
7 in the health services often emphasize that more for
8 the community, the mass, not as the individual. It
9 seems to us there is all too little recognition of the
10 fact that disease can be prevented, a lot of diseases
11 and all too often insurance schemes seem to be patterned
12 or directed towards treating someone after they are ill
13 rather than trying to prevent the disease. In other
14 words, to give you a specific example, I am aware that
15 the practitioner in areas I serve cannot collect a fee
16 for examining a child for pre-school entrance, and that
17 is the implication there. That preventive services
18 should be paid for.

19 COMMISSIONER VAN WART: Are the
20 immunization services paid for by any of the plans?

21 DR. STURGEON: Not all of them.
22 Certainly I can say that. The net result is that the
23 Health Department is thrust into the position of doing
24 more preventive services than they should. In other
25 words, many of these should be done by the practising
26 physician.

27 COMMISSIONER VAN WART: Turn to section
28 25. Would you enlarge a little bit upon that? You
29 started to enlarge when you were reading it.

30 DR. STURGEON: As I said, the reference
was to information coming from Australia. I don't know
too much about these types of plans. I only know what
I read but it seems to me that the payment for medical



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Therefore, it seems that society, if they want to provide medical service, as far as the cost of medical service, that is a proposition between Society in general and as individual, or family in contrast to having it involved with the actual provision by the Doctor.

COMMISSIONER VAN WART: Coming to section 27, the priorities enumerated here. By "priority" you mean that emphasis should be placed on these various things that you have given, but do you mean that they should be carried out before any voluntary insurance plan is evolved or should they go on side by side?

DR. STURGEON: I think it is important that they go on. We, as Public Health people, are conscious that we are not directly involved in the provision of care to individuals but we recognize that these are important. Infant mortality in particular.

THE CHAIRMAN: Why are your infant mortality and maternal death figures, as you say, out of line in Ontario?

DR. STURGEON: Well again speaking from personal ---

THE CHAIRMAN: You go on to say we are low down in the scale?

DR. STURGEON: Yes, related to other countries like the Scandinavian and low countries and so on, New Zealand.

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5 certificates that infants dying, that possibly a lot of
6 them could be avoided. I would think that a goodly
7 percentage could be avoided if people, or mothers,
8 consulted their doctors as soon as they should and
9 continued; did not do foolish things. That may be
10 overcome by health education. It is a complex matter.
11 I don't think that we Canadians should be too proud of
12 our infant mortality rate.

13 COMMISSIONER STRACHAN: You refer
14 principally to the pre-natal period?

15 DR. STURGEON: The pre-natal period
16 mostly.

17 COMMISSIONER BALTZAN: What other
18 reasons may there be in Canada that put us on this lower
19 level? Absence of techniques or methodologies? What
20 is the basis for this lagging behind?

21 THE CHAIRMAN: Perhaps the question
22 may be a little bit broad for Dr. Sturgeon. You are
23 dealing with Ontario.

24 COMMISSIONER BALTZAN: On a general
25 basis. You have read into this thing more, perhaps
26 than a lot of other people. It seems all through the
27 country that the same sort of thing is reported. It is
28 rather surprising because, generally speaking, we
29 thought our standards very high, and in this connection
30 we do not seem to measure up. We find it very difficult
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Sturgeon

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hospitals and less mid-wifery, if there is anything against that, and yet our results are not so good.

DR. BULL: I think that the fault is not in the technical service. I think the quality of medical care is extremely good in Ontario.

I would feel that it is probably the result of lack of health education. Lack of sufficient information to our parents. In some instances it is the result of sparsely populated areas having poor medical service. In some of the more remote areas of the Province we do not have sufficient medical service, I think. And hospital care is not so readily available in the more sparsely populated area.

Statistics indicate that the infant mortality rates are lower in the southern portion of the Province, in the areas particularly around larger cities.

COMMISSIONER STRACHAN: How does Ontario compare with the Dominion? The overall Dominion?

DR. BULL: Ontario has a lower rate than the Dominion as a whole.

THE CHAIRMAN: You would expect that.

COMMISSIONER VAN WART: We had a group appear with a statement on sanitation, plumbing, and so on, that it wasn't what it should be in many places of Ontario. Is that universal in the rural areas?

MR. ROBSON: Did you say, sir, that you had already had a group here to speak in that way?

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4 public health standards for housing. I would say that.

5 In my experience, I should emphasize
6 that this has nothing to do with the building codes or
7 structures. It would be a minimal public health standard
8 for housing.

9 THE CHAIRMAN: They were complaining
10 of water pollution particularly, even in the lakes,
11 houseboats, many things.

12 MR. ROBSON: Oh yes, that is an
13 increasing problem sir.

14 THE CHAIRMAN: They thought the
15 standards in regards to cess pools and so forth were
16 bad.

17 MR. ROBSON: It is a universal problem
18 at the moment. The density of population and the volumes
19 of creeks and the increasing industrial waste is
20 presenting a problem. They are working on it all the
21 time.

22 THE CHAIRMAN: They were relating all
23 these things to this matter of infant mortality.

24 MR. ROBSON: Yes. Well, there is no
25 question that a good environment has a bearing on health
26 but it is so complex and it would be difficult to say
27 that a person died from so and so.

28 However, we do know, strictly from a
29 point of view of what we see, that we feel that control
30 of dwelling houses is hardly adequate under the existing
legislation. We feel that minimum standards should be
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4 THE CHAIRMAN: They are recommending
5 that everything would be all right if the National
6 Building Code was adhered to.

7 MR. ROBSON: No sir. The National
8 Building Code deals mainly with structure, cubic
9 capacity, et cetera. Most of the houses are overcrowded.
10 Even our modern houses are overcrowded within the terms
11 of the Public Health Act.

12 However, even in an overcrowded modern
13 house, provided you have modern sanitary facilities,
14 conveniences, you can maintain a reasonably good standard
15 but if you overcrowd an old type of house where you have
16 a privy, possibly six, seven children, poor well and
17 these children have to go to school amongst other children,
18 from the environmental point of view we always worry
19 about that type of thing. They do not have adequate
20 sanitary conveniences. They may not have a sink in
21 the house.

22 THE CHAIRMAN: I think we can follow
23 that without too much elaboration. Dr. Bull, is there
24 not a continuous audit of infant mortality in Ontario?

25 DR. BULL: Yes sir.

26 THE CHAIRMAN: So you do know what the
27 cause of all these deaths within the first year, within
28 the first month and so for this?

29 DR. BULL: Yes sir.

30 DR. STURGEON: Quite frankly, Mr.
Chairman, Members of the Commission, paragraph 28 is
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They create problems for everyone and

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THE CHAIRMAN: Well now, Doctor, I don't want to carry the discussion any further than may be necessary and relevant but our greatest area, the area in which the mortality rate is highest, is away from the Metropolitan area. Away from the area where you have this concentration of the hard core that you are speaking of.

The figures in the places where the hard core exists are better than the other areas. Doesn't that add up to something? Therefore, we are 12000

DR. STURGEON: Possibly could, but I still say, again I refer to my own community. A small city of say 115,000 people.

THE CHAIRMAN: You would have a very good cross section of Rural Ontario there.

DR. STURGEON: Yes. These are the group of people that cause me all the problems. My nursing staff. Sanitarians, medical people as well.

COMMISSIONER VAN WART: This group appeared before us and recommended that we have more sanitary inspectors. Would you agree with that?

MR. ROBSON: No. We have today a certain amount of statutory enforcement but the day for that is -- we now prefer to possibly educate. You can only do a certain amount of it, of that type of thing. I think you have to depend on people to behave themselves and live properly.

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THE CHAIRMAN: Now, you recommend in 30 fluoridation of communal water supplies. Beyond the acceptance of the principle, what do the Public Health authorities throughout Ontario do to bring this about? This situation that you say is so desirable. What is done to bring it about?

DR. STURGEON: Well sir it is a process of education. You see, we have to accept the fact that there are certain legislations in this Province that says that it can be -- it is permissive. It can be established by the municipality but if certain groups demand a vote, certain percentage of the population, you have to go through that. Therefore, we are faced with the problem of public education and having gone through one vote already, I can say that that is a very large task.

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The opposition seemed to have adequate funds to promote anti-fluoridation, but it can be. We were fortunate, and had a successful vote, but it does not happen like that all the time. We have to work within legislation. Despite the fact the Committee didn't recommend that, the legislation that did appear stated that there would be certain limitations, so we are therefore faced with a certain public education effort.

COMMISSIONER VAN WART: Your public health education; does it emanate from the provincial Health Department or does it emanate from the local health units?

DR. STURGEON: Well, the local Department has to do it, sir. It may come down. There are consultants at the provincial level who may advise us, but actually it is thrust upon us at the local level, where it should be, as a matter of fact.

THE CHAIRMAN: Dr. Sturgeon, have you any other observations to make at this time before we close, or any one of the ladies and gentlemen with you?

MR. ROBSON: In my introduction, Mr. Chairman, I should have said that Dr. Bull is our Director at large, in addition to representing the Medical Office of Health. I am sorry for the omission.

THE CHAIRMAN: Dr. Sturgeon and ladies and gentlemen, we want to thank you for going to the trouble and the great detail in which you did in the submission and the making up of your brief, and for your attendance here this morning, and for your



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willingness to discuss these problems with us, and to
point out the matters which you think are of particular
importance, as you have done. We are grateful to you
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DR. STURGEON: Thank you, sir, and
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THE SECRETARY: Mr. Chairman, the next submission is that of the Canadian Hemophilia Society, Ontario Chapter, which will be Exhibit 345, and Mrs. Rosenthal will come forward to introduce this submission.

--- EXHIBIT NO. 345: Submission of the Canadian Hemophilia Society, Ontario Chapter.

SUBMISSION OF THE CANADIAN HEMOPHILIA SOCIETY,
ONTARIO CHAPTER.

Appearances: Mrs. Joe Rosenthal
Mrs. L.E. Bedard
Mr. W.H.H. Bishop

MRS. ROSENTHAL: My name is Mrs. Joe Rosenthal and I am President of the Ontario Chapter of the Canadian Hemophilia Society. On my right is Mrs. L.E. Bedard, a Director of our Chapter and on my left is Mr. W.H.H. Bishop.

Was there anything in particular you wished to discuss?

THE CHAIRMAN: No, if you wish to open up the matter, and we will likely have, following the order of having the recommendations or summaries read, and any supplementary statements or explanations which you may wish to make, and then we will have some discussion as it may appear necessary, having regard to the details as given in the brief.

MRS. ROSENTHAL: We will take page 2, the summary of our main recommendations, paragraph 6.

The Canadian Hemophilia Society,



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MRS. ROSENTHAL: We will take page 2,
the summary of our main recommendations, paragraph 6,
the Canadian Hemophilia Society.



Rosenthal

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Ontario Chapter, offers these main recommendations, which are specifically concerned with Hemophilia.

(i) Every general hospital should have trained personnel, streamlined administrative procedures, and blood products in quantities, organized to meet possible emergency of this chronic illness - Hemophilia.

(ii) A regional system of centers located in a university city or town and affiliated with the teaching hospitals and teaching research institutions, would enable the Hemophiliac to enjoy "totality of treatment" and approach to his chronic illness - Hemophilia.

(iii) Some system of quick identification of Hemophiliacs should be instituted in all hospitals in order to insure minimal delays upon admittance.

(iv) It should be mandatory that only deft doctors or technicians tackle the veins of a Hemophiliac when making a venapuncture for a transfusion.

(v) Funds required for approved Hemophilic research should come from the consolidated revenues of the Government of Canada.

(vi) The Ontario Chapter of The Canadian Hemophilia Society requests that a



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Rosenthal

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grant be allotted to the Chapter to enable it to fulfil the aims and objectives of the Society.

(vii) A census of Hemophiliacs ought to be made in Canada to facilitate the wise distribution of "Hemophilic totality centers",

The Chapter's other recommendations are of a subsidiary or general character.

THE CHAIRMAN: Mrs. Rosenthal, 6(iii); some system of quick identification. That is something that would be carried by the individual personally?

MRS. ROSENTHAL: That is true.

THE CHAIRMAN: I mean, is that what you have in mind?

MRS. ROSENTHAL: That is true as far as emergencies are concerned, but we feel that if a hemophiliac could be identified as far as records are concerned, that it would help him in admittance procedures.

THE CHAIRMAN: What do you mean by records?

MRS. ROSENTHAL: We recommend a cross-index on page 7, item 8; at the top of the page we say:

"The Hemophiliac is given a card, - a cross-indexed registration card - bearing the essential information of his case which he is to carry with him at all times."

THE CHAIRMAN: That is right. Well now,



Rosenthal

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where would the hemophiliac obtain such a card today?

MRS. ROSENTHAL: Well, we find that, of course, the hemophiliac goes generally to the hospital in his locality, and will have a long history.

THE CHAIRMAN: Some may go a little further, they may travel around.

MRS. ROSENTHAL: In this given hospital there would be this cross-index card for treatment but we also have a wallet card that we supply to them.

THE CHAIRMAN: This is the thing the individual ---

MRS. ROSENTHAL: We have a wallet card and we have a disc that they wear about their neck in time of emergency, that says their name and address, and their blood type and: "I am a bleeder." These are free of charge.

THE CHAIRMAN: How are they obtainable?

MRS. ROSENTHAL: The hemophiliac applies to our Chapter and they are donated to them.

THE CHAIRMAN: How does he become aware that he may do that?

MRS. ROSENTHAL: We hope that the hemophiliac, through the hospitals and word of mouth, and our publicity ---

THE CHAIRMAN: Somebody tells him?

MRS. ROSENTHAL: That is right.

THE CHAIRMAN: And that is a matter of just getting ---

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Bedard 11913

MRS. BEDARD: The Toronto hospitals are setting up records of hemophiliacs. However, this is not true in every hospital and we depend on a physician's desk index. We are listed there. We depend on the social planning council. We are listed there. As means of publicity through the para-medical services. Then we depend on publicity in the general fields and in the regular news media in addition to that.

THE CHAIRMAN: (v) on page 3, you say:

"Funds required for approved hemophilic research should come from the consolidated revenues of the Government of Canada."

Where are funds coming from for research that is now being done?

MRS. ROSENTHAL: In appendix D, page 5, we list the grants that have been requested to our organizations for research. We, in our own Chapter, have been able to sponsor the first two research applications to the extent of 1,900 dollars and that is all.

THE CHAIRMAN: Where do your funds come from?

MRS. ROSENTHAL: Our funds come from membership fees, a very small internal fund drive, and general donations.

THE CHAIRMAN: Internal; that is among the people with whom you work?

MRS. ROSENTHAL: That is right. Friends



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MRS. ROSENTHAL: That is right. Friends



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and relatives.

THE CHAIRMAN: You have not gone to the public generally?

MRS. ROSENTHAL: Not as yet, but we may have to go to them. We are working this out with the United Appeal and Social Planning Council in the Toronto area on this point.

THE CHAIRMAN: How widespread is the disease?

MRS. ROSENTHAL: We estimate there are 2,300 hemophiliacs in Canada, of which 750 would reside in Ontario which we would be concerned with.

THE CHAIRMAN: Percentage-wise, of course, that is very small?

MRS. ROSENTHAL: One in 8,000.

COMMISSIONER VAN WART: That is true hemophiliacs, or do you include such as Christmas Disease, and all these kindred ones?

MRS. ROSENTHAL: We include all the others.

COMMISSIONER BALTZAN: How big is this Canadian Society, the membership?

MRS. ROSENTHAL: I couldn't say.

COMMISSIONER BALTZAN: I just ask that for orientation. Can you say offhand how large your membership is in Canada?

MRS. ROSENTHAL: I don't know the actual numbers, but we do have four Chapters across Canada, in the Provinces of British Columbia, Manitoba, Quebec and Ontario.



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Rosenthal

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3 COMMISSIONER BALTZAN: And how big
4 is your own Chapter here?

5 MRS. ROSENTHAL: Our group here, well,
6 I would say we have about 250 paid members, and
7 approximately, we have registered 200 sufferers of
8 the disease.

9 COMMISSIONER BALTZAN: Do a large
10 number of these members belong to families in whose
11 families there are hemophiliacs, or is it spread
12 pretty widely across the general population?

13 MRS. ROSENTHAL: Well, so far, due to
14 the fact that we are so new, most of them are from our
15 hemophilic families, or relatives, but we have picked
16 up quite a few medical people and educationalists
17 through the last few years. Our membership is expanding,
18 and we are quite pleased with this.

19 COMMISSIONER BALTZAN: It occurs to
20 me, while you are dealing primarily with the hemophiliac,
21 could you not, or do you also, take in other bleeding
22 tendencies?

23 MRS. ROSENTHAL: Yes, our Constitution
24 calls for all hemorrhagic diseases.

25 COMMISSIONER BALTZAN: As, for instance,
26 the people who are being treated for various things
27 with anti-coagulants, are they also labelled?

28 MRS. ROSENTHAL: Well, the three basic
29 hemophilic classes, Christmas Disease, P.T.A., and
30 there are many new ones coming up, so our Constitution
is quite wide.

COMMISSIONER BALTZAN: One is new but



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COMMISSIONER BALTAN: One is new but



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very old in name, and that is Christmas Disease.

Do many of your things that you speak of here as most desirable seem to be related to better organizations in hospitals, as for instance, being in a hospital ready to do the right thing and that totality of service, and then you also advocate regional centres and let's go back to the individual hospitals.

Number one, has your Society done much in the way of constructing hospitals, or departments of hospitals, and alerting them to proceeding along the lines that you spell out here?

MRS. ROSENTHAL: On the provincial level I am afraid that this is something that we are very conscious of, and would like to go ahead on. On the national level, we have succeeded, at least, they have down in Montreal succeeded in setting up an adult clinic at St. Mary's Hospital, where the hemophiliac is serviced from all aspects of the disease regularly.

I might say, on page 6 of our brief, item 13, we outline how we would set up the centre and this is based on this centre that has already been in operation for some years at St. Mary's. It is also applied at the Sick Children's Hospital in Montreal for the hemophilic children.

COMMISSIONER BALTZAN: So you are confining yourself primarily to that for which your Society is named and that is an admirable branch of activity. All this that you speak of about organizing, hospital, classification and identification, etc., is already being done on quite a wider scale, and that is by the Society of Hematology, the international Society

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Now, do you still feel that this constitutes a single entity and you would like to proceed just along that line that you are confining your activities to, or would you follow the course of the Society, International Society's study of blood diseases and incorporate a lot of the other diseases in the Society?

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MRS. ROSENTHAL: Well, both.

COMMISSIONER BALTZAN: When you speak of research, you want money just devoted specifically for the study of haemophilia disease, because societies are receiving grants, donations, there is research continuing, as you know, in teaching hospitals, university centres, and haemophilia is one of the major subjects of study.

MRS. ROSENTHAL: I might say we have not submitted our medical research because our national organization will be submitting it in Ottawa. But from our own point of view, we feel that haemophilia has been neglected as far as research is concerned. It is true that there are very closed research projects which might turn up with an answer to haemophilia, but the basic research in haemophilia has been neglected.

COMMISSIONER BALTZAN: That is probably quite true, and we are not discussing it from any other point of view, except that we are trying to discuss the question as a whole and separate out societies and allocation of funds. We want your reaction as to how the whole thing can be met, whether it can be incorporated in the whole classification of diseases or ----

MRS. ROSENTHAL: My feeling is that such research people as Dr. Jaques of Saskatoon and Dr.



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Monkhouse of Toronto, all came to us and asked that we sponsor these projects, and on the basis of our medical board, which is a very good board as far as haemophilia is concerned, has approved all these projects, and we feel that they should be sponsored.

COMMISSIONER BALTZAN: That is very good, these projects, specific projects in relation to the general scheme.

MRS. ROSENTHAL: Yes, that is right.

COMMISSIONER BALTZAN: I think that is all. Thank you.

THE CHAIRMAN: This matter of the recommendation 4, at the foot of Page 2, the matter of transfusions, etcetera, provided the patient has the identification card or medallion that should warn the hospital people not to just be too loose in taking blood, and so forth. But the blood supply itself you get through the Red Cross Blood Transfusion Service now.

MRS. ROSENTHAL: This is a matter of education, I am afraid.

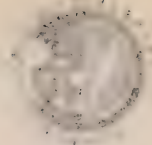
THE CHAIRMAN: Yes, I know, but you concerned here with the method of doing it. Are you concerned with the problem of obtaining blood transfusions?

MRS. ROSENTHAL: Oh, certainly we are, because it is natural if they can't afford --

THE CHAIRMAN: I mean to say having lost it, is there a supply available to you?

MRS. ROSENTHAL: Yes, the Red Cross.

THE CHAIRMAN: That is the supply you depend on?



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MRS. ROSENTHAL: Yes, entirely.

COMMISSIONER STRACHAN: Mr. Chairman, regarding identification, I don't suppose it is original, but is tatooing considered at all for identification, where it would be on the person permanently and never missing as a card or a disc might be?

MRS. ROSENTHAL: I have read that, but we haven't considered it in our organization.

COMMISSIONER STRACHAN: What percentage of the estimated 750 in Ontario have sought identification?

MRS. ROSENTHAL: Well, we have only been organized five years and we have registered 200. Not all of them want identification; some feel it is not necessary.

THE CHAIRMAN: Not even the card?

MRS. ROSENTHAL: Most of them take the card when supplied, but not all of them ask for the disc.

COMMISSIONER BALTZAN: You say that a lot of these people, even though it is explained to them, still remain quite ignorant, don't divulge it. I read in here that education of the sufferer must continue, because 50% still don't know. Nobody knows exactly the cause. What do you mean by that, that they don't know?

MRS. ROSENTHAL: They don't know the cause? Oh, well, many families cannot trace haemophilia in their history.

COMMISSIONER BALTZAN: After, say, the first instance of bleeding or the second and somebody begins to think quite seriously about the matter, then a

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them, still remain quite ignorant, don't divulge it. I
want to point out that education of the sufferer must continue,
because 500 still don't know. Nobody knows exactly the
cause. What do you mean by that, that they don't know?
MRS. ROSENTHAL: They don't know the

cause? Oh, well, many families cannot trace leprosy

first instance of disease on the record and somebody
begins to think quite seriously about the matter, then a



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diagnosis is made and the diagnosis is given. Is that final? Do they appreciate it to the extent that they are alerted, ready to inform any hospital, or is that still not enough?

MRS. ROSENTHAL: It depends on the severity of the disease in the individual. Some people think they can ride through the episodes and others immediately do something about it, and they are the people who would get the disc and carry through.

COMMISSIONER BALTZAN: I am thinking of them telling or informing immediately that they belong to the haemophiliac types.

MRS. ROSENTHAL: Perhaps the fact that it is hereditary and they feel there is a stigma attached to it and they don't want people to know that they have it and they keep it to themselves.

COMMISSIONER BALTZAN: That is the reason for the statement that 50% don't talk about it?

MRS. BEDARD: We have had people who carry discs and even a wallet card and even a letter from their physician stating what to do in terms of the last treatment they have been receiving arrive in Toronto and being in a major centre in Toronto, because they don't know what to do with that patient, and after considerable delay this patient contacted us and asked us --- our liaison man, to whom we would refer in that hospital, happened to be away, and the mechanics were such that this patient, in spite of this identification, did not get prompt treatment. Which brings us back to this cross-indexing in centres so that if a patient went

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to North Bay the haematologist there would consult the central area about that patient and get the latest information.

As you know, many of the patients do not know the intricacies and should not necessarily know the intricacies of their own treatment, and yet they can be better informed of their own treatment than the person who is going to treat them. So identification is only adequate insofar as the persons they are going to encounter, receive it and know how to handle it.

COMMISSIONER BALTZAN: That wasn't exactly my question, but I am very pleased with your added information, that all hospitals cannot possibly have this on hand, and it is quite true because it isn't always a question of blood transfusion, there is always the question of liaison factors that must be contained in the blood plasma, and in this case you say they were unprepared, when the person brought this information to the hospital, they couldn't do anything for the person.

MRS. BEDARD: The patient was in considerably longer than we would have expected to so identify his case. As you know, the sooner the patient receives the proper medication the more rapid will be his recovery and the less chance of joint deformities, and so on. So it is not just a matter of impatience on the part of lay people or the patient but ----

COMMISSIONER BALTZAN: Are you listed with most hospitals? Is there an organization where this information is obtainable? Are hospitals acquainted with it?



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THE CHAIRMAN: Not hospitals; the doctors.

COMMISSIONER BALTZAN: When I say the hospitals, I mean the departments and staffs would be informed.

THE CHAIRMAN: Are you suggesting that there are doctors in Canada that don't know there is a Haemophilia Society?

MRS. BEDARD: Yes, there are plenty.

THE CHAIRMAN: Then I don't know that this Commission can do much about it.

MRS. BEDARD: We are as far as possible circularizing, we print a bulletin eight times a year, and although it is done at a lay level, it contains probably the most up to date information we can obtain, and we circularize all the Medical Associations, the Dental Association, the Public Health Nurses' Association, many other conventions that will put up a place to distribute our bulletin and literature.

We also have a medical board which is, in our opinion, quite illustrative, and we assume that they in their various panels and discussions when this topic comes up refer to it.

THE CHAIRMAN: You will have to get a detail man.

MRS. BEDARD: If we had funds.

THE CHAIRMAN: Mr. Bishop, do you have anything to add?

MR. BISHOP: Yes, I would like very much to mention two or three things in the brief.



11322 Bedard

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Bishop 11923

I am particularly concerned about the admittance procedures in hospitals. I feel that this is something that should be dealt with. It is in a very sad state, really deplorable. There are several places in the brief where something is mentioned about this. At Page 2, Paragraph 6, Section 1, and Page 2, Paragraph 6, Section 3. I will just read these through so that they can go into the record. Page 4, the second half of Paragraph 7; Page 5, Paragraph 9; Page 7, Paragraph 16.

Now, these items have something to do with admission procedures. We wouldn't be so concerned about this problem if we knew it hadn't been handled satisfactorily in other places. It has not been handled satisfactorily in Ontario. It has been handled satisfactorily in other places. In Britain there is a registration of haemophiliacs, it was formed in 1942. The same of the States; there has been very decisive work done in connection with the facilitating of emergency admissions and emergency treatments. For instance, in Los Angeles there are two hospitals, children's hospital, adults' hospital, where someone coming in just has to present the registration card to have not only rapid treatment, but actual admission without a physician's, without being presented by a private physician. There are all sorts of arrangements that have been done in various places. We feel that in Ontario this is perhaps in a sense a complex thing. It needs the cooperation of the Ontario Medical Association, Ontario Hospital Association, probably the Hospital Services Commission, and our Medical and Scientific Advisory Board.



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We have approached the Ontario Hospital Association, the Ontario Medical Association and the Ontario Hospital Services Commission and we feel that if there was identification of a hemophiliac he should be able to go to any hospital in Ontario and have acceptably rapid admitting and the commencing of treatment. It is not terribly difficult to understand what treatment is necessary because the joint technical blood group of the American Medical Association have set out recently just what is needed in treatment of personal problems under certain conditions; if he has anemia he gets one type of product and if he is hemorrhaging badly he gets another. This appears in the April 12th issue of the Journal of the American Medical Association. We feel there is enough knowledge now that hospitals administration and personnel should be aware of how to handle the emergency cases if the hospitals were informed of this fact, if there was something, perhaps an item that was sponsored by the Ontario Medical Association, the Ontario Hospital Association and sent to each hospital they would have something that would inform them of the correct procedure for dealing with emergency admittance and treatment procedures.

COMMISSIONER BALTZAN: I seem to get this impression and I want you to correct me if I am wrong, that considering your difficulties of admission, et cetera the emergency entry, is every bleeding incident -- I should ask this of a doctor but speaking in terms of a lay person concerned as an individual -- is every bleeding incident regarded as a crisis?



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 We have approached the Ontario Hospital Association.



Bishop

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4 MR. BISHOP: Oh, indeed not. On the
5 other hand, there is sort of an organized impression that
6 the bleeding is always of an exterior nature and this
7 is not so. The transfusion procedure for trying to
8 abort hemothrosis is a very important one and the sooner
9 it is commenced the more chance the doctor has of
10 actually stopping a joint bleeding that might well lead
11 to some deformity. This is what the chief hemotologist
12 at St. Mary's Hospital meant when he set up his arrange-
13 ment in 1953 and he say this was an arrangement to be
14 organized with a view to supplying fresh frozen plasma
15 to abort hemothrosis. This is one of the developments
16 with the hemophiliac at a hospital in what might be
17 considered an emergency condition. It very often is
18 some joint bleeding and apparently fresh frozen plasma
19 product if given rapidly can abort the seriousness of
20 the joint bleeding.

21 COMMISSIONER BALTZAN: Thank you, I
22 will not pursue that any further.

23 THE CHAIRMAN: Thank you very much,
24 ladies and gentlemen. You bring forward a relatively
25 small matter, relative to population but important to
26 those who suffer from the disease. The information you
27 have given us in your brief will go to our research
28 people and will be before us in our considerations.
29 Thank you very much.

30 We will recess for a few minutes.

---Short recess.

MR. BISHOP: Oh, indeed not. On the

other hand, there is sort of an organized impression that

the bleeding is always of an extensor nature and this

is not so. The transfusion procedure for trying to

abort hemorrhage is a very important one and the sooner

it is commenced the more chance the doctor has of

actually saving a limb. I think that is the case.

to some deformity. This is what the chief hematologist

at St. Mary's Hospital meant when he set up his arrange-

ment in 1953 and he says this was an arrangement to be

organized with a view to supplying fresh frozen plasma

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have given us in your brief will go to our research

people and will be before us in our considerations.

Thank you very much.

We will recess for a few minutes.



THE SECRETARY: Mr. Chairman, the next brief is that of the Canadian Psychoanalytic Society and the Canadian Institute of Psychoanalysis. This will be known as exhibit number 346.

---EXHIBIT NO. 346: Submission of Canadian Psychoanalytic Society and The Canadian Institute of Psychoanalysis.

SUBMISSION OF
CANADIAN PSYCHOANALYTIC SOCIETY
and
THE CANADIAN INSTITUTE OF PSYCHOANALYSIS

APPEARANCES: Dr. W.C.M. Scott
Dr. A. Parkin

THE CHAIRMAN: Dr. Scott, I will leave it to you to proceed as you may see fit.

DR. SCOTT: I think we might refer you to the summary which begins on page 8.

This brief contains a definition of psychoanalysis and a short account of its organizational growth, both internationally since 1908 and in Canada during the past ten years. Facilities for psychoanalytic education in Canada, together with an outline of the training offered, are given in detail, and the present extent of psychoanalytic practice is outlined.

The main conclusions and recommendations to foster both psychoanalytic education and facilities for psychoanalytic treatment are:

(1) Government subsidies should be



next brief is that of the Canadian Psychoanalytic Society
the Canadian Institute of Psychoanalysts. This will be
known as exhibit number 186.

Submission of Canadian
Psychoanalytic Society and
The Canadian Institute of
Psychoanalysts.

---EXHIBIT NO. 186:

SUBMISSION OF
THE CANADIAN INSTITUTE OF PSYCHOANALYSIS
and

Dr. W.C.M. Scott
Dr. A. Parnis

APPENDICES:

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The main conclusions and recommendations
to foster both psychoanalytic education and facilities
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(1) Government subsidies should be



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4 available for training in psychoanalysis in the Canadian
5 Institute of Psychoanalysis.

6 (2) Government grants should be
7 available for research.

8 (3) Treatment of patients who need
9 psychoanalytic treatment, either in hospital or in out-
10 patient departments, should be available to the extent
11 that other needed treatments are available.

12 THE CHAIRMAN: By that do you suggest
13 that in any form of prepaid medical service that might
14 come about that treatment by your specialty should be
15 recognized as is the treatment of any other specialty?

16 DR. SCOTT: That is so in France and
17 in England, Great Britain, and I think if a prepaid
18 system becomes available here it should also be available.

19 THE CHAIRMAN: What about the present
20 prepaid schemes like P.S.I., where do you fit into that
21 picture or do you presently fit in?

22 DR. PARKIN: Yes, they do pay a certain
23 proportion of the fee and will accept psychoanalytic
24 treatment as a thing to which they will partially
25 contribute to the cost.

26 THE CHAIRMAN: To what extent?

27 DR. PARKIN: I think about \$5.00 on
28 the consultation depending upon the fee, it may be 20%
29 to 25%.

30 THE CHAIRMAN: Why the limitation? Do
you know why? Has it ever been explained? Is it merely
they do not want to pay any more or is there some
substance or reason for it?

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DR. PARKIN: Yes, they do pay a certain

proportion of the fee and will accept psychoanalytic

treatment as a thing to which they will partially

contribute to the cost.

the consultation depending upon the fee, it may be 10%

to 25%

THE CHAIRMAN: Why the limitation? Do

you know why? Has it ever been explained? Is it merely

they do not want to pay any more or is there some

explanation or reason for it?



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DR. PARKIN: I have no knowledge as to how the P.S.I. ---

THE CHAIRMAN: Do you think it is fear that the cost would be too high?

DR. PARKIN: That may be but to my knowledge they do not pay a full cost for any ---

THE CHAIRMAN: Do you mean to say your organization has never inquired?

DR. PARKIN: About P.S.I.?

THE CHAIRMAN: Yes. Why you are not treated as a surgeon or a pathologist or an orthopaedic surgeon?

DR. PARKIN: To my knowledge I do not know that we are treated any different in this respect.

THE CHAIRMAN: I thought you said there was a limitation on the amount?

DR. PARKIN: Yes.

THE CHAIRMAN: I think we heard there was a limitation on the amount paid for psychiatric treatment, do they class psychoanalysis in the same general character as psychiatric treatment?

DR. PARKIN: Yes.

THE CHAIRMAN: Is that because it is a relatively new thing and has not been fully accepted or what?

DR. PARKIN: Do you mean psychiatric treatment generally?

THE CHAIRMAN: Yes, it has not acquired the maturity that others have.

DR. PARKIN: I think there is no doubt

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to how the P.S.I. ---

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DR. PARKIN: I think there is no doubt



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a psychiatric treatment generally requires more personal
time devoted to it by the physician than any other form
of treatment.



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THE CHAIRMAN: What about your treatment? It is fairly intensive?

DR. PARKIN: More still.

THE CHAIRMAN: We may qualify for certification, I don't know, by the time they are through with this Commission. We have tried to psycho-analyze public feeling all over Canada. It's going to take us quite a while too.

COMMISSIONER VAN WART: Are you considered specialists by P.S.I. and the rest?

DR. PARKIN: No. Many of our members may be also, at the same time, certified with the Royal College of Physicians and Surgeons as specialists but not in psychoanalysis.

Several years ago there was a request by the Royal College of Physicians and Surgeons to our Society to meet with them and consider the possibility of the Royal College examining our graduates in order to bring our graduates under a particular certification of psychoanalysis. This consultation came to nothing. There had been some consultations, I think, in the States but they have come to nothing.

COMMISSIONER VAN WART: Under P.S.I., in the case of remuneration, do they treat you like other specialties? Pay you on an indemnity system, pay part of the fee and you collect the rest from the patient?

DR. PARKIN: Exactly.

COMMISSIONER VAN WART: Just the same as they do with specialists?



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DR. PARKIN: That is the way.

COMMISSIONER VAN WART: That would be the mechanism rather than other causes?

DR. PARKIN: Well, the mechanism, I think, is that just as you say with the P.S.I. they will pay a proportion and the patient pays the rest. This can either be done in one of two ways. Either by the patient paying the total fee and then collecting a certain portion of that back again or the other way around.

THE CHAIRMAN: But the Royal College does not recognize psychoanalysts as specialists?

DR. PARKIN: Right.

THE CHAIRMAN: Except through psychiatry?

DR. PARKIN: Correct.

COMMISSIONER BALTZAN: Are all psychoanalysts psychiatrists or can one follow the discipline of psychology and branch off and train in psychoanalysis?

DR. PARKIN: Yes. In Canada we follow the European model, Great Britain, France, etc., which is unlike the American model in accepting lay medical people for training.

In the United States it is required that an M.D. be held.

THE CHAIRMAN: What do you mean by "lay medical people"?

DR. PARKIN: Sorry. I mean non-medical, lay people medically, from a medical point of view. We do accept people from related fields, which is sociology, psychology, for training. Psychology, perhaps,



DR. PARKIN: That is the way.

COMMISSIONER VAN WART: That would be

the mechanism rather than other causes?

DR. PARKIN: Well, the mechanism.

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Parkin

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would be the chief representative of the non-medical fields.

COMMISSIONER BALTZAN: Is there much demand for psychoanalysis, both in diagnosis and treatment in Canada?

DR. PARKIN: I think it would certainly be fair to say that every one of the members of the Canadian Psychoanalytic Society cannot possibly do the work that is demanded of him.

COMMISSIONER STRACHAN: What percentage of your Society have the medical degree?

DR. SCOTT: All but three. Three out of 29.

DR. PARKIN: Have not.

DR. SCOTT: And students; two out of 40 are non-medical.

DR. PARKIN: On Appendix G in the brief you will see - sorry, that is students. Appendix A will give a list there of our members and the various university positions they hold.

If you look down Appendix A you will see that most, the vast majority of the members, hold positions in university departments of psychiatry, chiefly three in Canada. University of Montreal, McGill University, University of Toronto, with the exception of those people who are trained in psychology, which would be Professor Chentrier, Professor Lussier, page 2 of Appendix A.

COMMISSIONER STRACHAN: Since you have non-medical members, would that not bar you from

1944.

COMMISSIONER BALDWIN: Is there much

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Page 2 of Appendix A.

COMMISSIONER STACHAN: Since you

have non-medical members, would that not bar you from



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any association with the Royal College?

DR. PARKIN: No, it was not the stumbling block. They are, non-medical members are required by our own Society to be supervised by a medical person. They file a written obligation to do so. If a non-medical person is accepted for training then he signs an obligation that if he eventually achieves the qualifications in this specialty that his work will be supervised by a medical person.

This has not created any difficulty in the negotiations which I spoke of between the Society and the Royal College.

COMMISSIONER STRACHAN: Supervision by any medical or a medical of your Society?

DR. PARKIN: Any medical, but, of course, by choice it would be one of the people of our own Society.

COMMISSIONER BALTZAN: You receive people coming directly, or must they always be referred in order to obtain from you the results of the need for that form? Does an individual come to you directly?

DR. PARKIN: Many of them do, but there is always an attempt, if they approach the psychoanalysts directly, to have him come by way of a general practitioner, internist, medical person of some sort. Many of them who do not have perhaps a family doctor, it is not usually demanded of them if this can be seen to mean that they might then be deprived of an opportunity of such a consultation.



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If a consultation is had in this way, then it is usually desirable to arrange, at some time, that the patient obtain a family doctor to whom the patient can then be referred back.

COMMISSIONER BALTZAN: Following along the same line, whether people come to you directly and you receive them directly; now, does it depend upon treatment, applied treatment? Must you have first some knowledge about the general physical condition? Are there any limitations that a certain type of individual's condition is not either amenable or can withstand it, whatever the process is?

DR. PARKIN: I think a certain proportion of people coming to us either directly or by way of somebody else, some other specialty, even if they had not had their physical examination, it is desirable that they do.

In another group of cases - another percentage - I think the clinical examination itself is sufficient to rule out any type of complicating factor in other areas.

COMMISSIONER BALTZAN: Thank you.

COMMISSIONER GIRARD: Your curriculum calls for a four-year course and the first year is almost entirely devoted to the psychoanalysis of the candidate.

DR. SCOTT: That is right.

COMMISSIONER GIRARD: Is this course taken as a part-time course or is this full-time?

DR. SCOTT: In the first year it will



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Scott

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be part-time only. Taking one hour of the student's time per day.

In the next year, when lectures and seminars are added, might take on the average of perhaps another hour with reading, and in subsequent years when the student is treating one, two and three patients under supervision, finally adds up to, say, six or seven hours in a day in the last year.

COMMISSIONER GIRARD: So it is full-time after the first year?

DR. SCOTT: Except that usually doctors work much more than six or seven hours a day.

COMMISSIONER GIRARD: Where are the courses given? Are they given in universities?

DR. SCOTT: Not in this country and only in a few centres in the States and not in England and not in France. The course is given and arranged by the Canadian Institute of Psychoanalysis and the teachers are in Vancouver, Toronto and Montreal. The students take part of their training in Toronto and Montreal and lectures and seminars are in Montreal at the moment.

When there are sufficient teachers in any one area, then a full course can be given in that area but, as we have mentioned in the brief, training only began a very short time ago in Canada and several years ago an attempt was made to start it in a university but that did not succeed and now this training is developed very actively under the Institute which is the case in about 17 out of the 20 Institutes in the



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Perhaps three of them are very closely associated with universities. Years ago medical schools were not part of universities and many specialties, like orthodontal surgery, paediatrics, developed outside the university for many years before they became part of the university.

COMMISSIONER GIRARD: I add this because I know three of the university professors whose names are here and I was wondering if these people were giving their courses in the university?

DR. SCOTT: No. They will be teaching psychiatry or teaching about analysis rather than teaching it.

DR. PARKIN: They have a joint teaching activity, so to speak. One to the university in which they hold an appointment and in which they will be teaching, as Dr. Scott says, psychiatry and as leavened by their psychoanalytic knowledge, their other activity would be teaching to the psychoanalytic students in the Institute, which has nothing to do with the university in which they will be teaching not about psychoanalysis but psychoanalysis.

COMMISSIONER GIRARD: Is the prerequisite of psychoanalyzing candidates during their first year, and part of their second year, I think I saw in your curriculum, is that to see if they have the qualifications to become psychoanalysts?

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3 are going to do. The original selection attempts to
4 exclude those who would not be capable of becoming
5 analysts but a certain proportion of accepted students
6 will, as it were, fail or decide that they would
7 rather be something else than analysts.

8 Many of the personal analyses is to
9 enable the individual to know themselves and to know
10 themselves quickly and easily so that they can use
11 that knowledge of themselves in their own development
12 in observing another person because one problem that
13 arose very early in the psychoanalytic training was
14 the fact that so many people knew so little of their
15 own development, that everybody has one kind of neurosis,
16 an infantile neurosis. They have forgotten their
17 childhood. That must be alleviated if one is going to
really understand the childhood of an adult or a child.

18 COMMISSIONER GIRARD: I see also in
19 your prerequisites that you mention nursing. What
20 background would a nurse have to have in order to be
acceptable as a student in psychoanalysis?

21 DR. SCOTT: She would have to have an
22 interest in doing more for individuals than she would
23 in her ordinary course of nursing. I am thinking of
24 two examples. One was a nurse who went into psychiatry
25 and then became a Sister tutor in a psychiatric hospital
26 for intensive treatment and she is now an analyst and
27 is working half-time in the hospital and half-time in
practice.

28 COMMISSIONER GIRARD: She would have
29 to have a basis in psychiatry?
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Scott

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DR. SCOTT: Yes, except one famous nurse who made quite a lot of contributions to other analysts years ago and who was a paediatric nurse and we hope, of course, that some paediatric nurses will become interested because you see from the brief children tend to be neglected.

It's very difficult to get analysts to be interested in the analysis of children.



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DR. SCOTT: Yes, except one famous
nurse who made quite a lot of contributions to other
analysts years ago and who was a paediatric nurse
and we hope, of course, that some paediatric nurses
will become interested because you see from the brief
children tend to be neglected.
to be interested in the analysis of children.



/AG/ss.

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DR. PARKIN: I think, talking of nurses, one would have to distinguish between the two streams of training by which women do become nurses. That is, within and without the university. Insofar as we require at least a university degree in the subject, whether it be in psychology, sociology, or whatever, it would be one required to lead to a degree, and which would require a certain amount of psychological, sociological, knowledge, as given in the university curriculum.

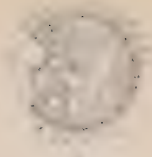
COMMISSIONER BALTZAN: Is psychoanalysis a separate discipline, or is it a branch of psychiatry, psychology, or any other subject?

DR. PARKIN: Well, historically psychoanalysis developed out of the practice of one man, the psychiatric practice of one man, but in terms of its contribution, it has made its contribution to many more fields in medicine. It has made enormous contributions to sociology, and I think the whole subject of sociology is in the last 30 or 40 years, has been greatly indebted to psychiatric contributions, and although psychoanalysis developed from psychiatric origins, it has spread far beyond the bounds of psychiatric medicine.

COMMISSIONER BALTZAN: This curriculum, one enters then either your institute or the university originally and immediately with the intention of ultimately becoming a psychoanalyst; is that correct?

DR. PARKIN: One applies to the institute if one wishes to become a psychoanalyst, yes.

COMMISSIONER BALTZAN: Very briefly, what are the preliminary requirements?



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 ...of training by which women do become nurses.
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 becoming a psychologist; is that correct?

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 Institute if one wishes to become a psychologist, yes.

that are the preliminary requirements



Parkin 11940

DR. PARKIN: That they hold a university degree, as set forth on Page 3 of the training program in the brief.

COMMISSIONER BALTZAN: That is fine, I have my answer.

THE CHAIRMAN: Thank you very much, Dr. Scott and Dr. Parkin. We have the brief, and it will enable us to appreciate much more than certainly I myself previously did the work of your specialty, and the place that it ought to take in any general comprehensive program that might be fashioned in the future. Thank you very much.

DR. PARKIN: May I thank you very much for considering our brief.

THE SECRETARY: Mr. Chairman, the next submission is that of the Christian Science Committee on Publication for Ontario, and Mr. Tufts will come forth and speak to this submission, which will be Exhibit No. 347.



... as set forth on Page 8 of the training program in the brief.

COMMISSIONER BULLMAN: That is fine.

I have an answer.

THE CHAIRMAN: Thank you very much.

Dr. Scott and Dr. Parkin, we have the brief, and it will enable us to appreciate much more than certainly I myself previously did the work of your specialty, and the place that it ought to take in any general comprehensive program that might be fashioned in the future. Thank you very much.

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THE SECRETARY: Mr. Chairman, the next

submission is that of the Christian Science Committee on Publication for Ontario, and Mr. Lott will come forth and speak to this submission, which will be Exhibit No.



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---EXHIBIT NO. 347: Submission of the Christian
Science Committee on Publication
for Ontario.

SUBMISSION OF
THE CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR ONTARIO

APPEARANCES:

MR. LESLIE A. TUFTS

THE CHAIRMAN: Mr. Tufts, having regard
to the fact that your brief is not long, perhaps you might
prefer to read it entirely, and to interpolate as you see
fit any observations as you go along.

MR. TUFTS: Why yes, I would be glad
to do that, Mr. Chairman, it is true it is not a long
brief, and that might be the most practical way of getting
at it.

Mr. Chairman and Members of the
Commission: My name is Leslie A. Tufts and I am the
Christian Science Committee on Publication for Ontario.
As spokesman for the Christian Scientists of Canada in
federal-legislative matters, I should like to present a
brief statement on behalf of the Church of Christ,
Scientist, regarding the question of health services now
pending before your Committee. My appearance before you
has been authorized by the Christian Science Board of
Directors, the administrative head of the Christian
Science denomination.

Incidentally, the Christian Science



Submission of the Christian
Science Committee on Religion
for Ontario.

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THE CHRISTIAN SCIENCE COMMITTEE ON RELIGION FOR ONTARIO

THE CHAIRMAN: Mr. Tolson, having regard
to the fact that your brief is not long, perhaps you might
prefer to read it briefly, and to intersperse as you see

fitting. I am glad
to do that, Mr. Chairman, it is true it is not a long
brief, and that might be the most practical way of getting

Mr. Tolson and members of the
Commission: My name is Louis A. Tully and I am the

representative for the Christian Scientists of Canada in
federal legislative matters. I would like to present a
brief statement of the work of the Church of Christ,

Christianity, regarding the question of health services now
being before your Committee. My appearance before you
has been authorized by the Board of Directors of the
Church, the administrative body of the Christian

Scientist, the Christian Scientist



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Board of Directors are located in Boston, Massachusetts, where the Mother Church is.

THE CHAIRMAN: Mr. Tufts, how many adherents in Canada are there, I mean in a general way?

MR. TUFTS: Mr. Hall, you have asked me a question that I am not permitted to answer.

THE CHAIRMAN: Oh, I see. All right, thank you.

MR. TUFTS: I might explain. There is a provision in our Church Manual to the effect that we must not number our church members.

THE CHAIRMAN: The only reason for the question is to see how large the group is for whom the special consideration that you are asking is applicable.

MR. TUFTS: I wish I were free to give you that information, but we are bound by that regulation in the Manual.

THE CHAIRMAN: Well, we appreciate your position.

MR. TUFTS: Thank you very much.

We understand the the objectives of your Commission are "to inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians." (Statement of Hon. Emmett M. Hall as reported in Canadian Journal of Public Health, November, 1961). We also

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understand by statement of Right Honourable John G. Diefenbaker, The Prime Minister, as reported in "Hansard" of February 14, 1961, that, "when the Commission has made its report the question of the problem of health insurance will have to be considered by the government in the light of the recommendations made."

In anticipation of these prospective recommendations and their possible effect on the Christian Scientists of Canada through the introduction of subsequent legislation, this brief is respectfully submitted.

Any program of health insurance which requires all individuals to contribute to a fund for health insurance which provides only for medical benefits discriminates against those individuals who, for religious reasons, rely on prayer or spiritual means alone for healing. We feel that the fundamental principle of freedom of choice will be denied unless consideration is given to this question. One of the basic points of our Canadian Bill of Rights is the freedom to worship God according to the dictates of individual conscience - to rely upon God for aid and succor under all circumstances - equality and protection before the law.

Since you asked your question, sir, it has just come to me that I could tell you that we have about 80 churches in Canada, and that might be some indication of the attendance there.

THE CHAIRMAN: At least 80 communities

MR. TUFTS: Yes, that is true.

We, therefore, request on behalf of all residents of our Dominion who are members or adherents

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Since you asked your question, sir, it has just come to me that I could tell you that we have about 10 churches in Canada, and that might be some indication of the attendance there.

THE CHAIRMAN: At least 80 committees.

MR. TROTTER: Yes, that is true.

Yes, therefore, request on behalf of all residents of our Dominion who are members or adherents



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of a Christian Science church, that their individual right as Canadian citizens to rely upon prayer and spiritual means alone for the prevention and healing of human ailments, be respected and preserved in conformity with the democratic ideals long established by our Constitution. Christian Scientists feel that their method of healing sickness by prayer, which is an inseparable part of their religion, is a constitutional right which should be respected and protected by our laws.

For these reasons, we request exemption, if possible, from all compulsory participation in any government-sponsored health plan which provides only medical benefits. If exemption is found to be impossible, or impracticable, perhaps a plan embodying cash option or some form of recognition of our method of healing can be authorized. We believe that, should a program underwritten by private insurance companies be adopted, a Christian Scientist should be entitled to receive payment for Christian Science treatment by a Christian Science practitioner, and for Christian Science nursing care and subsistence in a Christian Science sanatorium, nursing home, or in his own home, while under Christian Science treatment. However, we do not favor seeking payment for the services of a Christian Science practitioner in any program which is administered entirely by the government, since we would not want to have our practitioners placed under government regulation, supervision, or control. Under such a government-administered and supported program, we would seek payment only for Christian Science



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assistance in a Christian Science sanatorium, nursing

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nursing care and subsistence in the individual's own home, while under Christian Science treatment.

Therefore, we respectfully request that in any health insurance legislation the term "other remedial care" be included in addition to authorized medical care. In using the term "other remedial care" it would need to be understood that it is designed to include nursing care for those relying on Christian Science care and treatment. It would also be expected that subsistence allowance, where it is made available to those depending upon medical care, would also be made available to those relying upon "other remedial care." The phrase "other remedial care" is recommended because it would permit the authorization of Christian Science treatment and care without being subject to attack as class legislation, as might be the case should the phrase "Christian Science care" be used.

Perhaps it would be helpful if I give you a brief explanation of our method of healing. Christian Scientists, because of their religious teaching and faith, do not employ medical treatment and care. They rely wholly on spiritual means for healing, as did Christ Jesus. They respect sincerely the unselfish effort of doctors, surgeons, psychiatrists, and others. They respect the rights of each individual to choose that mode of health care which seems to him most efficacious. When confronted with sickness or disability, a Christian Scientist turns to a Christian Science practitioner for help through prayer instead of to a doctor; when in need of hospital care, a Christian Scientist prefers to go to

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a Christian Science sanatorium, whenever possible, rather than to a medical hospital.

Healing by prayer as understood in Christian Science has now been tested before the public for some 90 years. During this time a great body of evidence as to its efficacy in healing every sort of disease, has been established. The weekly and monthly publications of The Christian Science Publishing Society always contain a number of unsolicited, carefully verified testimonies of healing from Christian Scientists and others. These include numerous healings of organic as well as functional disease, of malignancies, pronounced fatal by competent medical authorities, as well as of obviously neurosthenic disorders. Many of these cases have long medical histories behind them; in many instances the expert diagnosis made before the patient turned to Christian Science for healing, had been supported by x-ray examinations, laboratory tests, and so forth. Not infrequently doctors who have observed these healings have stated frankly that only God could have wrought them.

In The Christian Science Journal, the official organ of the Christian Science denomination, is found a list of approximately 8,000 Christian Science practitioners, there are probably 120 or 125 of these in Canada, who have met the requirements of the Church for engaging in the full-time practice of Christian Science healing. The Journal also includes a list of carefully trained Christian Science nurses who are available to give the special care that may be necessary during a severe illness or incapacity. They do not, of course, give any medication.



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/BL/hm

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Two sanatoriums are maintained by the Church where such nursing care is available to those needing it during the course of Christian Science healing. The Church also approves various privately operated sanatoriums which meet the necessary standard for providing such care for those under Christian Science treatment. One of these privately-run sanatoriums is located in Victoria, British Columbia. Another one is in the process of being established in Ontario. In addition, there are numerous nursing and convalescent homes operated privately by and for Christian Scientists.

Christian Science treatment and care is known to be a safe and effective therapeutic system, so much so that Christian Science practice is protected by law in every province in Canada and every State in the United States. For example, when the United States Congress enacted the Social Security Amendments of 1960, Public law 86-778 (the Kerr-Mills Act), a provision was included authorizing "any other medical care or remedial care recognized under State law." Senate Report No. 1856, 86th Congress, page 7, interprets this phrase as follows:

"Accordingly, a State may, if it wishes, include medical services provided by osteopaths, chiropractors, and optometrists and remedial services provided by Christian Science practitioners."

We strongly feel that all persons entitled to benefits from any government-sponsored health



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3 insurance program which may be adopted should be free
4 to employ the practitioner or mode of treatment of
5 their choice. It should be axiomatic that a democratic
6 government has no more right to set up any one branch
7 of the healing art, and require its citizens to conform
8 to it, than it has to stipulate the particular religious
9 doctrine to which its citizens should subscribe.

10 Christian Scientists, from their sincerest and highest
11 motives, and with every desire to be obedient to the
12 laws of the land, yearn to be loyal to conscience and
13 to the form of religion they are professing to follow,
14 their only desire being to protect their method of
15 healing and to preserve their freedom to depend upon
16 it under all circumstances.

17 As previously indicated, recognition
18 of our method of healing would establish no precedent.
19 The United States Civil Service Commission's Government-
20 wide Indemnity Benefit Plan for federal employees pro-
21 vides that any participant may elect to receive Christian
22 Science benefits in lieu of medical benefits, thus
23 preserving the right of Christian Scientists to partici-
24 pate in the Plan without having to compromise their
25 religious rights and convictions. I am enclosing a
26 copy of the official brochure which explains the Plan,
27 and this is the brochure which was attached to the brief.
28 You will note that references to Christian Science
29 benefits are given on pages 7 and 12. There is also
30 further brief reference at page 23.

In addition, hundreds of insurance
companies today recognize Christian Science in their



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3 various health and accident policies; as well as in
4 liability and casualty policies. For example, the new
5 "Connecticut 65" health insurance plan for older
6 citizens of Connecticut includes recognition of Christian
7 Science. This plan, underwritten by some of the leading
8 insurance companies domiciled in Connecticut, is
9 available to all citizens of that State over 65 years
10 of age.

11 It might be appropriate to state that
12 the religion of Christian Science demands of its followers
13 the strictest observance of all laws pertaining to the
14 prompt reporting to the public health authorities of
15 suspected cases of infectious or contagious diseases,
16 and compliance with all isolation and quarantine
17 regulations, as well as the observance of all laws
18 applying to the welfare of minors. Special informative
19 instructions have been prepared in booklet form, under
20 qualified legal supervision, and made available for the
21 guidance of all Christian Scientists in these respects.
22 This booklet is entitled "The Legal Rights and Obligations
23 of Christian Scientists in Ontario." I will be
24 happy to leave a copy with the Secretary.

25 THE CHAIRMAN: If you will, Mr. Tufts.

26 MR. TUFTS:

27 It is solely because of their religious
28 significance and the dangers of unintentionally
29 inflicting upon Christian Scientists undue restrictions
30 which would restrict and discriminate against the free
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4 From the standpoint of religious
5 freedom, and in the interest of preserving that sacred
6 right, the Christian Scientists of Canada respectfully
7 request that the term "other remedial care" and the
8 following general provision be included by any compulsory
9 health insurance legislation:

10 "Nothing in this Act shall be construed
11 "to require any person eligible for
12 "benefits hereunder who relies on or
13 "is treated by prayer or spiritual means
14 "alone by a duly accredited practitioner
15 "of a well recognized church or
16 "denomination in accordance with the
17 "tenets and practice of such church or
18 "denomination to undergo any medical
19 "or surgical treatment. Such person
20 "shall receive benefits as fully as
21 "if medical or surgical treatment were
22 "employed."

23 We feel that our request is reasonable,
24 fair, and just. It is based on a sincere desire to
25 co-operate with our government in the protection and
26 welfare of the citizens of Canada as a whole. We know
27 that it is not the desire of your Commission, the
28 government or Parliament to interfere with religious
29 rights, and we pray that careful consideration be given
30 to our position.

Thank you for the opportunity and
privilege of presenting our views on this important subject



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Tufts

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THE CHAIRMAN: Thank you, Mr. Tufts. The fullness, the completeness of your submission within the limits that you intended to deal with makes it unnecessary perhaps for much discussion. But it may be said that we are obliged to you. The principle that you enunciate here, of course, not only applies to Christian Scientists, it applies to all religious groups in Canada, so when you discuss the principle you not only speak for yourself.

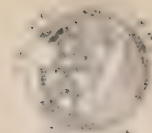
MR. TUFTS: That is true. And that is why in our legislation we prefer to have it specified as religious freedom or something of that kind, rather than use the term "Christian Science," to get away from the use of that particular term.

THE CHAIRMAN: You will be good enough to let us have that booklet.

MR. TUFTS: I will be happy to do that. I might say that there are about 18 Christian Science nursing homes in the United States and Canada. There is one in British Columbia, the other 17 are in the United States.

THE CHAIRMAN: Yes, there is a question I wanted to put to you if you are able to give me the information. Does that reference to the sanatorium in Victoria and the proposed one in Ontario, are these sanatoria recognized by the Hospital Commissions in the various places as hospitals to which payment is made under The Hospitalization and Diagnostic Services Act?

MR. TUFTS: No, I think not. The one in British Columbia is recognized in some form in British



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The fullness, the completeness of your submission within the limits that you intended to deal with makes it unnecessary perhaps for much discussion. But it may be said that we are obliged to you. The principle that you enunciate here, of course, not only applies to Christian Scientists, it applies to all religious groups in Canada, so when you discuss the principle you not only speak for yourself.

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THE CHAIRMAN: You will be good enough

to let us have that booklet.

MR. TUTTS: I will be happy to do that.

I might say that there are about 18 Christian Science nursing homes in the United States and Canada. There is one in British Columbia, the other 17 are in the United States.

THE CHAIRMAN: Yes, there is a question

I wanted to put to you if you are able to give me the information. Does that reference to the sanatorium in Victoria and the proposed one in Ontario, are these sanatoria recognized by the Hospital Commissions in the various places as hospitals to which payment is made under the Hospitalization and Diagnostic Services Act?

MR. TUTTS: No, I think not. The one

in British Columbia is recognized in some form in British



Tufts

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4 Columbia law as a private hospital; that is the
5 description that is in the legislation.

6 THE CHAIRMAN: It is not recognized
7 as a hospital under the Act?

8 MR. TUFTS: No, I think not.

9 THE CHAIRMAN: For which the operating
10 charges are paid.

11 MR. TUFTS: No, I think not. I believe
12 it does not come under that kind of recognition.

13 THE CHAIRMAN: Is there any thought
14 that the one in Ontario will be dealt with differently?

15 MR. TUFTS: We haven't gotten to the
16 point where that will have to be considered, but I would
17 say it will be likely be on the same basis as the one
18 in British Columbia.

19 Mind you, I think I saw in this
20 indemnity benefit plan -- of course, this is an insurance
21 company plan -- while it does cover five million civil
22 service employees in the United States, it is administered
23 by the insurance companies, the Aetna Life and those
24 associated.

25 THE CHAIRMAN: That would be similar
26 to the program that covers the federal civil servants
27 in Canada, which is administered by a group of insurance
28 companies, coverage is provided by the companies?

29 MR. TUFTS: Yes.

30 THE CHAIRMAN: Do you know whether or
not similar provision has been made under that type of
coverage in the civil service program in Canada as in
the United States?



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Tufts

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4 MR. TUFTS: I don't think so. I have
5 been watching that to see if any action has been necessary
6 by us. We haven't done anything about it, we have made
7 no requests. There has been new legislation, and we
8 thought we would let that be established before making
9 a request of that kind.

10 Coming back to this British Columbia
11 hospital of ours, it is recognized now in the income
12 tax plan; that is something which we have obtained just
13 within the past couple of years. In the income tax plan
14 in Canada our practitioners are now recognized and they
15 are mentioned.

16 THE CHAIRMAN: The payments made to
17 them are included in the 3% or 4%, the amounts which
18 may be deducted?

19 MR. TUFTS: Yes, on the same basis
20 as the medical doctors. Nurses are not mentioned there,
21 but nurses are included, and also this hospital in
22 British Columbia.

23 COMMISSIONER GIRARD: Mr. Tufts, in
24 the government indemnity benefit plan there is a descrip-
25 tion of Christian Science nurses as having completed
26 nursing training at an association sanitorium.

27 MR. TUFTS: Yes.

28 COMMISSIONER GIRARD: Does it also
29 have a graduate of another nurses' training course?
30 Would the graduate have any other training course, if
she did not give medication would she be recognized as
giving Christian Science nursing?

MR. TUFTS: Yes. But I understand they

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Tufts

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2
3 would have to train about six months in one of our
4 sanatoria; I think that is the regulation on that point.

5 I have a brochure here, Training Course
6 for Christian Science Nursing. I seem to recall that
7 there must be a very brief period of training in one of
8 the Christian Science sanitoriums, that would be the
9 one in Chestnut Hill, Massachusetts, nor the one in
10 San Francisco, California.

11 COMMISSIONER GIRARD: Would it be
12 possible to obtain the brochure?

13 MR. TUFTS: I could obtain one for you.
14 It is given under the direction of the Mother Church.
15 I have marked some sections there in red for my own
16 information.

17 THE CHAIRMAN: Thank you again, Mr.
18 Tufts. We are receiving submissions from other religious
19 organizations today; we think it appropriate that we
20 should do so.

21 MR. TUFTS: We are glad we are the
22 first ones. Thank you Mr. Chairman and Commissioners;
23 I am very grateful to you.
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11955

THE SECRETARY: Mr. Chairman, if I may, on our revised schedule of May 28th I have numbered as 137 three submissions to be taken into the record. I would like now to state what exhibits these will be and how they will be taken into the record.

The first one is The Canadian Home Economics Association which will be numbered 348 and the recommendations contained therein at pages 6 and 7 be part of today's record.

--- EXHIBIT NO. 348: Submission of The Canadian Home Economics Association.

SUBMISSION OF THE CANADIAN HOME

ECONOMICS ASSOCIATION

RECOMMENDATIONS FOR IMPROVING EXISTING HEALTH SERVICES

Within the terms of reference of the Royal Commission on Health Services, and based on the foregoing, the Canadian Home Economics Association respectfully submits for consideration by Commission members the following recommendations:

1. The continuance and expansion of existing grants and scholarships for undergraduate and post-graduate education to alleviate the existing shortage of qualified home economics in order to expand and diversify health services.

2. The employment of more nutritionists in federal, provincial and municipal departments of health.

3. Since home economics education supports the physical and mental well-being of both



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3. Since home economics education
supports the physical and mental well-being of both



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boys and girls, this subject warrants equal status with other secondary school subjects.

4. The inclusion of home and money management in adult education programs in urban areas.

5. The establishment of additional courses for auxiliary workers, such as food supervisors and staff for homemaker services, to permit maximum use of the limited supply of home economists.

6. The further development of programs for physically handicapped homemakers and extension of dietary guidance in out-patient departments.

7. Co-ordination of facilities for the distribution of factual information directed to Canadian families, with the ultimate objective of the establishment of a consumer information service.

8. Welfare departments and private agencies be made aware of the contribution to be made by home economists in the field of family relations, with particular emphasis on homemaker services.

9. The provision of increased funds to meet the unfulfilled public demand for publications of the Nutrition Division, Canada Department of National Health and Welfare, the Consumer Section, Canada Department of Agriculture, and the Consumer Service, Canada Department of Fisheries. We further recommend the increased use of radio and television for the promotion of healthful food practices.

10. The encouragement of food and related industries to provide funds for a Canadian organization similar to the Nutrition Foundation (see



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Appendix) in the United States.

11. A review by government authorities of existing Food and Drug Regulations pertinent to food, to assess the present restrictive aspects of the regulations, with a view to permitting food industries to present to consumers additional factual nutrition information. This would increase the amount of material available for education.

CONCLUSION

The final recommendations submitted for consideration by members of the Royal Commission on Health Services deal only with those areas now under government jurisdiction or those that cannot be held the direct responsibility of The Canadian Home Economics Association. Finally, our Association accepts responsibility for certain obligations such as the continuing education of the employed home economist.



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THE SECRETARY: The next submission is from the Metropolitan Windsor Health Unit and this will be known as Exhibit 349. The letter of transmittal accompanying their brief of April 3rd, plus the summary of recommendations attached thereto, will be part of today's record.

--- EXHIBIT NO. 349: Submission of the Metropolitan Windsor Health Unit.

SUBMISSION OF THE METROPOLITAN
WINDSOR HEALTH UNIT.

Dear Sir:

Kindly refer to your letter of February 16th regarding submission of briefs.

To keep the channels of communication open between the City of Windsor, the Metropolitan Windsor Health Unit and the Commission, you will find herewith twenty-five copies of an article which was presented by me at the Ontario Public Health Association Convention on October 5, 1960.

This article is being sent to you in lieu of a brief. It was prepared upon request of my confreres in public health and deals with (1) Environmental Sanitation (2) Preventive Medicine and (3) Medical Care. It outlines the challenge which will be presented in these fields during the next ten years.

In view of the fact that the article was written prior to the appointment of the Royal Commission, it may be of interest as an unbiased view of public health needs as visualized by a medical officer

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SUBMISSION OF THE METROPOLITAN
WINDSOR HEALTH UNIT.

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It would seem to me that, as the Commission studies the many presentations for and against extension of medical care programs, the thoughts expressed in this study may help to keep the basic and developing needs of public health in focus.

Signed. John Howie
Medical Officer of Health
Director, Metropolitan
Windsor Health Unit

SUMMARY OF RECOMMENDATIONS

(BRIEF ON PUBLIC HEALTH SERVICES)

I ENVIRONMENTAL HEALTH (see page 2)

(1) That, far from de-emphasizing environmental health in future public health programs, the four sectors of sanitation, (water, food, air and shelter), present us with "a challenging opportunity for public health leadership and service."

II PREVENTIVE MEDICINE (see page 5)

(2) That the attention of the Commission be drawn to the fact that, in any comprehensive program of medical care, there will be a continuing and increasing need of public health services, in the fields of

1. Health Education
2. Nutrition
3. Communicable Disease Control
4. Accident Prevention
5. Child Health
6. Maternal Health

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Medical Officer of Health
Director, Health Unit
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PREVENTIVE MEDICINE (see page 3)

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Health Education



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7. Occupational Health and

8. Health in Retirement

III MEDICAL CARE (see page 6)

(3) That prepaid comprehensive medical, surgical and obstetrical care, along the proven lines of Windsor Medical Services, be encouraged.

(4) That public health programs in chronic disease be developed, based on case finding, follow-up, patient education and patient services, leaving medical treatment to the private physician.

(5) That health departments accept responsibility to ensure that integration of rehabilitation services and facilities be as complete as possible and that voluntary health and welfare organizations co-ordinate their activities.

IV COST (see page 8)

(6) That distribution of full-time health services be reviewed and that consideration be given to the formation of unit areas of, say, 100,000 population.

(7) That consideration be given to equalization of grants for rural, urban and suburban areas on a per capita basis.

(8) That recruitment of full-time health department personnel be intensified, that salary levels be improved and that bursary-supported programs be instituted or increased for the specialized training of medical officers of health and other public health personnel.

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specialization in public health in a two-year post-
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THE SECRETARY: The next submission is that of the Canadian National Institute for the Blind which will be Exhibit 350 and pages 6, 7 and 8, which are the recommendations of this brief, will be taken into today's record.

--- EXHIBIT NO. 350: Submission of the Canadian National Institute for the Blind.

SUBMISSION OF THE CANADIAN NATIONAL

INSTITUTE FOR THE BLIND

RECOMMENDATIONS

1. Medical Facilities. There should be hospital and clinic facilities planned to bring competent eye care to both the financially and geographically disadvantages. Clinics should include those permanently located in hospitals, plus travelling clinics and those set up in local communities for short periods. Unless early diagnosis and treatment can be increased, we are deliberately allowing blindness to occur. The greater use of ophthalmologists as consultants and teachers will lead to greater awareness of the conditions which may lead to blindness.

2. More Comprehensive Provision for Training of Personnel. Present facilities should be increased for the training of professional personnel. Universities should be encouraged to extend present medical courses. Those universities who do not have ophthalmological courses at present should be encouraged to introduce them. Provision should also be made for



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3 recruitment and training of nurses, social workers,
4 etc., who will specialize in the field of eye care.
5 Incentive grants for post-graduate training for ophthal-
6 mologists and to encourage their location in rural
7 areas would assist greatly in developing a more compre-
8 hensive coverage. At present ophthalmological training
9 for prescribing low vision aids is available only in
10 the United States. Funds should be made available to
11 provide this training in Canada and to extend the low
12 vision service to all major cities.

13 3. Public Education. The improvement
14 of existing services should include public education.
15 In this way Canadians will know what is available and
16 how and when to use the services. More emphasis should
17 be placed on eye health in the training of nurses,
18 teachers, general practitioners, nursery school workers
19 and social workers. The public should also be taught
20 more specifically on the care of the eyes and the
21 avoidance of accidents. Regional conferences bringing
22 university lecturers to districts outside major cities
23 would serve to bring home to more Canadians the impor-
24 tance of eye care, eye services and eye research.

25 4. Research. Current studies in eye
26 health point to the need of the establishment of centres
27 across Canada dedicated solely to the study of eye
28 diseases. At present none exists in Canada but greater
29 specialization and public interest indicate a need for
30 such centres. These centres would provide sufficient
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also serve to attract the necessary capable personnel



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into the field.

Today in Canada costs of blindness
soar into the millions. The CNIB
is now spending annually in its
service to the blind \$2,000,000.00.
Government allowances to 8572 blind
persons cost over \$5,000,000.00.

Other costs of blindness include the
following; Partial or total loss of
earning power for approximately 8000
men and women between the ages of
21 and 64.

Public cost of Mothers' Allowance
and other supplementary programs.
Special income tax exemptions.

Costs of special education for blind
children in 6 residential schools
across Canada as well as Sight Saving
classes and special tutorial services.

Thus the cost of blindness on all
counts is now crowding \$20,000,000.00 per annum.

Hence we are confronted with the very definite problem
of eliminating needless blindness, which from our
records and ophthalmological opinion is estimated at
50% of the total.

This situation is sufficiently serious
to warrant vigorous attack. Prevention of blindness
is a major weapon in this attack and for this we must
have strong and well developed medical services which
reach down to the local community level. This will be

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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

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3 accomplished only through comprehensive health services
4 adequately supported by government.

5 THE CHAIRMAN: We will adjourn now
6 until 2 o'clock this afternoon.

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9 --- Luncheon adjournment.
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until 2 o'clock this afternoon.

--- Luncheon adjournment.



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---On resuming at 2:00 p.m.

THE SECRETARY: Mr. Chairman, the first brief this afternoon is from the Department of Christian Social Service of the Anglican Church of Canada and it will be known as exhibit number 351.

---EXHIBIT NO. 351: Submission of the Department of Christian Social Service of the Anglican Church of Canada.

SUBMISSION OF
THE DEPARTMENT OF CHRISTIAN SOCIAL SERVICE
OF THE ANGLICAN CHURCH OF CANADA

APPEARANCES:

Prof. Gordon Watson
Canon Howard Buchner
Dr. C. Gossage
Rev. M.P. Wilkinson
Rev. J. Fisk

THE CHAIRMAN: Dr. Gossage, would you like to introduce your associates.

DR. GOSSAGE: Mr. Chairman and Members of the Commission: May I introduce the delegation of our Committee. Sitting on my right is Mr. Watson, Associate Professor of Religious Knowledge at Trinity College and an associate of the Toronto Psychiatric Hospital in psychiatry.

On my immediate right Rev. Buchner, acting Dean of Divinity at Trinity College. Mr. Wilkinson and Mr. Fisk, Mr. Wilkinson is the general secretary and Mr. Fisk is the secretary and field representative of the



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---EXHIBIT NO. 351:

SUBMISSION OF

THE DEPARTMENT OF CHRISTIAN SOCIAL SERVICE
OF THE ANGLICAN CHURCH OF CANADA

Prof. Gordon Watson
Canon Howard Buchanan
Rev. M.P. Wilkinson
Rev. J. Risk

ASSOCIATES:

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and Mr. Risk, Mr. Wilkinson is the general secretary and
Mr. Risk is the secretary and field representative of the



Gossage

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Council for Social Services.

I have the honour to submit a brief on behalf of the Anglican Church of Canada to you. This brief has been prepared by a Special Committee of the Council for Social Service of the Anglican Church of Canada. The Council, which is the Department for Christian Social Service of the General Synod of the Anglican Church of Canada has a responsibility in the health and welfare field, and welcomes this opportunity of appearing before the Royal Commission on Health Service.

2. With its deep concern for the provision of the best possible health, welfare and social services for all the people of Canada at reasonable cost, the Anglican Church believes that it has a particular responsibility for the adequate training of their clergy for their role in the provision of these services.

3. The Committee feels that representation will be made by the medical profession and others in specialized fields with respect to the provision of health, welfare and social services and therefore will devote this brief to (a) clarifying the role of the clergy, regardless of denomination and faith, as members of the health team, (b) underlining the need for adequate training courses to fit them for this role, and (c) emphasizing the necessity of providing suitable facilities for carrying out this ministry.

CONCLUSIONS AND RECOMMENDATION OF THE BRIEF

4. This brief maintains that the ministry of a highly trained and competent clergy has an essential

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CONCLUSIONS AND RECOMMENDATION OF THE BRIEF

4. This brief maintains that the ministry

of a highly trained and competent clergy has an essential



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4 place in our common responsibility for the health of
5 the nation.

6 5. We, therefore, recommend:

7 That the Government of Canada encourage and assist in
8 the setting up of adequate clinical pastoral training
9 for the clergy in hospitals and other institutions in
10 which it has or shares a financial or administrative
11 responsibility, and further that provision should be made
12 for chapels, quiet rooms or other facilities in such
13 institutions to enable the clergy to carry out their
14 ministry.

15 6. We suggest that the Government of
16 Canada do this by undertaking:

17 a) To invite and recognize the
18 formation of a joint committee, for example, of members
19 of the Canadian Medical Association, the Canadian Council
20 of Churches, the Roman Catholic Church, and the Jewish
21 Faith, appointed to establish and safeguard high
22 standards of clinical pastoral training.

23 b) To provide financial assistance,
24 by federal grants, so that this committee may create
25 such clinical training courses throughout the country
26 as it deems necessary, to be made available to all
27 suitable clergy at nominal expense, without the
28 burden of money raising falling on those concerned with
29 the organization and operation of such courses.

30 c) To encourage the provision in such
hospitals and institutions of a chapel, quiet room or
other facilities which would be available to patients
for the purpose of worship, meditation and prayer, and to
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c) To encourage the provision in such

hospital and institutions of a chapel, quiet room or other facilities which would be available to patients for the purpose of worship, meditation and prayer, and to the clergy for spiritual ministrations.



Gossage

11969

ESTIMATED PERSONNEL & COSTS FOR CLINICAL TRAINING

Six Week Course with six trainees and one supervisor

Supervisor work at cost of the US\$1200.

Honoraria for Lecturers

30 participants at \$20 600.

Secretarial Services 200.

Equipment, Stationery,
books, etc. 200.

Travel Expenses 100.

Bursaries 300.

\$2600.

Twelve Week Course with twelve trainees and two supervisors

Supervisor \$2400.

Assistant Supervisor 1800.

Honoraria for Lecturers

30 participants at \$20 600.

Secretarial Services 400.

Equipment, Stationery

books, etc. 300.

Travel Expenses 200.

Bursaries 600.

\$6400.

Expenses for joint committee \$200.

On the assumption of there being ten
six week courses and two twelve week courses annually,
the estimated cost would be \$40,000.00. We suggest that
ultimately courses be made available in major centres
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Six Week Course with six lecturers and one supervisor

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Gossage

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4 Then follows our brief, Mr. Chairman,
5 and following that is an example of one of the shorter
6 summer programs an outline is given in the appendix
7 along with a statment of cost of the Toronto Institute
8 for Pastoral Training. The interesting thing, if I
9 might just comment on that, is the fact which is easily
10 shown in the list of the committee of the tremendous
11 interest and leadership which the faculty of the University
12 of Toronto, including the Dean, both past and present,
13 professors of medicine and so on and so forth have given
14 in the establishment of this course.

15 That is the introduction and the
16 conclusions and recommendations.

17 If it is your pleasure Canon Buchner
18 will be the spokesman for questions, being a cleric I
19 thought it would be better than having a layman but the
20 rest of us will assist him.

21 THE CHAIRMAN: Thank you, Mr. Gossage.
22 This summer course in Clinical Pastoral Training is
23 actually now in progress?

24 CANON BUCHNER: Yes, it is.

25 THE CHAIRMAN: From May 14 to June 27?

26 CANON BUCHNER: Yes.

27 THE CHAIRMAN: That is one course that
28 is operating in Canada at the present time?

29 CANON BUCHNER: There are three courses
30 at the present time, one in Hamilton, one in Nova Scotia
and I believe there is a smaller one in Montreal.

REV. FISK: One in Montreal Verdun
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Gossage

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3 THE CHAIRMAN: I take it these are
4 now being support wholly in some way other than by
5 government grants?

6 CANON BUCHNER: Yes, Mr. Chairman.

7 THE CHAIRMAN: Is there any arrange-
8 ment through the Ontario Hospital Commission for any
9 salary or part salary for any chaplain in any hospital
10 in Ontario?

11 CANON BUCHNER: I do not know whether
12 there is not.

13 REV. FISK: There are some chaplains
14 who are supported, I do not know whether it is through
15 the Ontario Hospital Commission but they are supported
16 by government funds. For instance, there is a hospital
17 in New Toronto and one in St. Thomas which have full-time
18 chaplains who are state supported.

19 THE CHAIRMAN: When we were in Alberta
20 we had a submission in connection with the chaplain
21 service which was being carried out in Calgary; are
22 you familiar with the program there?

23 REV. FISK: I just know of it.

24 THE CHAIRMAN: They appeared to be
25 quite pleased with the progress they were making at
26 that stage but, again, it was more or less of a voluntary
27 effort than a supported one.

28 PROF. WATSON: May I make a comment
29 on these chaplains to perhaps underline the point made
30 in the brief that our concern is not exclusively with
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3 themselves in hospitals administering to their parishioners.

4 THE CHAIRMAN: I have heard references
5 to your recommendation number 6 on clinical pastoral
6 training, your recommendation that a joint committee be
7 set up for this purpose. I was wondering if you would
8 care to expand on that and perhaps open up the vista
9 of what you see might be a reasonably acceptable pro-
10 gram in that regard.

11 PROF. WATSON: I think we envisage,
12 Mr. Chairman, that in such a committee would reside the
13 responsibility for co-ordinating clinical training
14 across the country for setting the standards of excellence
15 and seeing that they are met in each case and for
16 accrediting those who are graduates of such courses so
17 that there is uniformity and so that any clergyman who
18 enters a hospital with such qualifications does so with
19 all the backing of such a joint committee. The reason
20 why it is joint is, of course, the medical professions
21 and related professions and the clergy share the
22 responsibility for these standards and stand behind the
23 men who work in hospitals setting sort of an example
24 to their brethern and colleagues in these various
25 disciplines. The amount of actual control that such a
26 committee would exercise over the individual courses
27 would have to be considered in great detail because
28 there are marked regional differences; predominantly
29 Roman Catholic districts would have to be treated
30 differently from predominantly non-Roman Catholic and
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Gossage

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4 hospital in the metropolitan area such as Toronto?

5 PROF. WATSON: Yes, most of the
6 clinical training courses are inter-denominational and
7 the amount of co-operation that exists on a very small
8 scale is remarkable so we feel it quite realistic to
9 propose this though it is only fair to point out that
10 so far the Roman Catholics have not been deeply involved
11 but have at least been interested and expected interest
12 in what goes on in non-Roman Catholic centres.

13 COMMISSIONER BALTZAN: Should not all
14 clergymen really be instructed and have this knowledge
15 that you wish now to see adopted through the medium
16 of these courses? That should be the aim of all the
17 clergymen? Now, after one takes a course of six weeks
18 or twelve weeks then he become proficient in the kind
19 of thing that you wish the clergymen to have and I would
20 like to know what the place would be of a clergyman
21 who is not able to or has not the time to obtain this
22 training. He would still function in the usual ministry
23 of the sick and this would then be what you call
24 specialists or is that your aim for all clergymen, all
25 denominations that so desire be informed of this clinical
26 socialological approach?

27 CANON BUCHNER: If I may respond to
28 this question; sometimes clinical training is given,
29 more particularly in the United States, but also here
30 in Canada to Divinity students. It is also felt that
those who have been ministering for a period of time
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3 is at present possible.

4 CANON BUCHNER: At present this year
5 there would probably not be more than I shouldn't think
6 twelve clergy in Canada receiving this type of training.

7 COMMISSIONER BALTZAN: Would you expect,
8 sir, before ordination, I think that is the word you call
9 it?

10 CANON BUCHNER: Yes.

11 COMMISSIONER BALTZAN: That a graduate,
12 one who is ordained, will receive that course before he
13 leaves, goes out in the field of ministry?

14 THE CHAIRMAN: Sort of a clinical
15 rotation in a hospital.

16 CANON BUCHNER: This would be useful,
17 but beyond this, this is something more useful: The
18 person who has already been out for a while, who has some
19 experience to relate it to.

20 COMMISSIONER BALTZAN: I am thinking
21 of your new graduate. The people who joined the ministry
22 before going out into their field.

23 DR. GOSSAGE: It is more at the post-
24 graduate level. This training is conceived as a post-
25 graduate type of training. There is some clinical pastoral
26 training at the undergraduate level, but it's more on a
27 post-graduate phase.

28 It is hoped that after the young clergy-
29 man has had some experience of life on the parochial work,
30 he is in a more receptive, more understanding position to
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Fisk 11975

to get this kind of training between their second and third year at seminary. We also assist clergy who have been out in the field for a number of years to get this kind of training. It's a very costly thing.

COMMISSIONER BALTZAN: Are you experiencing difficulty, when you mention about hospital Commissions making provision for chapels, other things you mention here where private administration has been made, resting areas, and so on, are you encountering any difficulty?

REV. WILKINSON: In some areas there is difficulty, although I must admit that for the past five to ten years the whole atmosphere has changed radically and there is a considerably more amenable response to a request for clergy, interdenominational groups for quiet room, chapel, multipurpose rooms that can be used.

COMMISSIONER BALTZAN: What response are you getting to this desire on your part?

REV. WILKINSON: It depends how successful the financial campaign is for building the new portion of the hospital.

REV. FISK: If there are sufficient funds left over.

THE CHAIRMAN: I think our questions will be aimed directly at Government participation in the providing of funds.

DR. GOSSAGE: That is right, sir.

THE CHAIRMAN: Is there any impediment in that respect? Is it recognized or not in the building of a hospital that a chapel is an integral part of the



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Wilkinson 11976

building costs which should be shared by Government as well as with the local community?

REV. WILKINSON: I can speak specifically of two hospitals of which I know. One in the Queensway and the second the South Peel Memorial, both of which have inter-governmental support as well as public support, both of which have been making provision, in cooperation with the local ministerial groups for chapel facilities.

DR. GOSSAGE: Mr. Chairman, I think it is fair to say it's the unusual thing, outside of the Roman Catholic Church hospital, to find a chapel, or facilities.

THE CHAIRMAN: Up to this point.

DR. GOSSAGE: Yes, sir.

THE CHAIRMAN: Nowadays, shall we say, a different view is taking hold and beginning to prevail. In one Province we learned that, for instance, the number of square feet, cubic feet of the building that was to be used for the chapel was not being recognized as a part of the sharable cost. I think this is the only one. There is no other Province that we heard any complaints about.

Now, I was just wondering what the situation was in Ontario?

DR. GOSSAGE: Mr. Chairman, I should not, perhaps, speak of anything of which I am not sure, but I don't think there is any allowance, or matching grant for space on a footage basis for chapel accommodation or such.

THE CHAIRMAN: Now, that is a recommendation you wish to make?



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Gossage 11977

DR. GOSSAGE: Very definitely, sir.

THE CHAIRMAN: It is very relevant for you to make to this Commission, because we are concerned with all aspects of hospital costs. Of construction grants and all operation grants, because the Federal Government in the first instance, makes a contribution on a formula that is called so much a bed, but it is much more than that, and then of course, in the operating, roughly 50% of the operating cost. So this is one recommendation that you wish us to take cognizance of here?

DR. GOSSAGE: Very definitely, sir.

THE CHAIRMAN: It may not present any real difficulty with your Provincial people in the long-run, once the idea does become accepted that there is a place for chaplaincy service in every hospital.

DR. GOSSAGE: Mr. Chairman, may I say this: We point out that the idea is to train clergy for their parochial administration. After all, we are all hoping there won't be quite so much hospitalization and that people will be cared for in their home. Then they will need their local parish clergyman in this supportive role. And this clinical pastoral training is designed for that too.

THE CHAIRMAN: The expectation is that you will be able to keep some people out of hospital?

DR. GOSSAGE: Right, sir.

REV. FISK: Hopefully.

THE CHAIRMAN: I think my medical friends would agree there is ground for the hope.

DR. JOSEPH: Very definitely, sir.

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Buchner 11978

COMMISSIONER BALTZAN: Go a little bit further on and say we have always recognized the need up until now of your share in the help and care of the sick.

THE CHAIRMAN: My fellow Commissioners are going very silent and the reason is quite obvious, that you have spelled out in the brief your ideas and what you think ought to be done.

I wonder if there is anything further you wish to develop while we are here.

CANON BUCHNER: Mr. Chairman, I think the one thing we would like to draw attention to is that one of the things we were really trying to do was to put to the Royal Commission a concept of health, an understanding of what health means about wholeness and integrity of the person.

We want to get this clearly across. Everything we feel and suggest depends upon this concept, and we are trying to spell it out in the brief as sharply as we can. If that is accepted, then it seems to us it is reasonable for us to bring these three recommendations to the Commission.

THE CHAIRMAN: I think that we understand that position from your brief and from what you have said here this afternoon.

COMMISSIONER BALTZAN: How many have you enrolled in these classes? What enrolment have you had so far?

PROF. WATSON: In the Toronto Institute of Pastoral Training course, sir, we have



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to the Royal Commission a concept of health, an understand-
ing of what health meant about wholeness and integrity
of the person.

We want to get this clearly across.

Everything we feel and suggest depends upon this concept,
and we are trying to spell it out in the brief as sharply
as we can. If that is accepted, then it seems to me it
is reasonable for us to bring these three recommendations
to the Commission.

THE CHAIRMAN: I think that we under-

stand that position from your brief and from what you have
said here this afternoon.

COMMISSIONER BURNETT: Now many have

you mentioned in these questions? What involvement have you
had so far?

DR. BURNETT: In the Toronto

Institute of Personal Learning course, sir, we have



Watson 11979

restricted the enrolment to six trainees per supervisor and we have kept the course working at that level with one supervisor due to the financial pressure and also the general availability of facilities.

The reason why there are so few is that it is sometimes a very strenuous undertaking and it submits the trainee to the kinds of experiences which I think and we all believe, he requires a great deal of guidance and assistance in order to meet it and get the most from it. I think that we are aware of the dangers implicit in introducing clergy, or any outsider to the very high-powered system of a hospital without being prepared to support him and to help him personally while he is going through this.

Now, the Toronto course with its six trainees can be compared with the Hamilton course which has about three times that number, I believe, but their course runs on a slightly different basis due to the particular circumstances in Hamilton.

I am not sure how many attend the Maritime courses, though I believe it is not nearly as large as the Hamilton one, so perhaps the total number in any one year, including all the courses in Canada might be in the neighbourhood of say, 40 or 45.

COMMISSIONER BALTZAN: But you would say that there are many more applicants, people who desire to take the course than you can possibly accommodate?

PROF. WATSON: Yes, that is true.

REV. FISK: We find this.

PROF. WATSON: We certainly find this.

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Watson 11980

We have to cut them out and set very high qualifications for entrance into the course.

REV. WILKINSON: This has considerable development, as you know, south of the line, but to send students there adds considerably to the cost and cuts the number we can afford to help to train as well as denying our own Canadian hospital facilities the opportunity for their own familiarization with the role that the clergyman can play in an adequately trained situation.

REV. FISK: For example, once more referring to the United States, there are certain seminaries which makes this a basic requirement of their course in pastoral care and all their students receive this kind of training.

COMMISSIONER BALTZAN: That is what I originally had in mind.

THE CHAIRMAN: Miss Girard has just drawn to my attention in French Canada there is a course in Montreal carried by the Dominican Fathers at the School of Medieval Studies called Ecole Pastorle which takes care of, I take it, of the students insofar as the French clergy is concerned.

REV. WILKINSON: It is a two-year post-graduate course. Once a student has graduated from his seminary, for two years he is enrolled at this school under supervision, and the same time he is employed, on a limited basis, in a pastoral scene, which amounts to a two-year interneship under training.

THE CHAIRMAN: You are familiar with what happens afterwards? Where does the young priest,



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Wilkinson 11981

who has had this training, go? Does he simply go out into pastoral work in Quebec, or is he attached more to hospitals?

REV. WILKINSON: Not particularly to hospitals.

THE CHAIRMAN: So that in that way, it is, by and large, pretty well the same type of program that you were talking about here for English-speaking Canada?

REV. FISK: Certainly there are those who have received pastoral training who return to the parish ministry rather than becoming chaplains in a hospital.

DR. GOSSAGE: Mr. Chairman, may I just mention the importance of good pastoral service, good, what shall we say, church affiliation and service, whatever denomination. As you are all aware, the high percentage of a physician's practice --- I happen to be one myself, is with some disturbances of a functional nature due to anxiety, stresses and strains and failure to adapt adequately to environmental situations.

Now, in the presence of good normal well-developed society, of which the Church is a very integral part, a lot of these problems are worked out before they ever reach the medical level. In other words, it's a preventive form of action.

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Gossage

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Then also if they do reach medical level and no organic basis is found, and things are explained, and they are encouraged to meet their situation and so on, again they are back in their parish, they are back in their local situation where their priest, or their clergy, or whoever they may be, can be of great help to them.

I think with the high incidence we have of functional ill health, this is a very important thing, to develop all facets of our society which make to the better approach to life.

COMMISSIONER BALTZAN: Then I might address you, Doctor, in this way. It might be a very good course for medical students.

DR. GOSSAGE: A very good course, yes.

PROF. WATSON: This is, in fact, one of the great features of the experience of these clinical training courses at the moment, that medical personnel and their colleagues in related disciplines, while perhaps reluctant and very reserved about the whole enterprise at the beginning, almost without exception express gratitude for the whole possibility of all that is offered them in understanding something of their own responsibilities, as well as the role of the clergyman. This is volunteered by many of the doctors and others on the staff, and gives us the sense that we do not only good for our clergymen, but also bring something of significance to the doctors as well.

COMMISSIONER STRACHAN: Are these courses now open to all, regardless of denomination and

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TORONTO, ONTARIO

Watson

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faith?

PROF. WATSON: Yes, they are, sir,
and we have had all denominations and faiths, except
the Roman Catholic, represented at any given time,
including an Orthodox Jewish Rabbi.

THE CHAIRMAN: Dr. Gossage and the
reverend gentlemen with you and Canon Buchner, we are
very grateful to you for having prepared this submission.
You have concerned yourselves with matters with which
you are particularly qualified to deal and to make
recommendations on, and I would like you to have our
assurance that the recommendations you have made will
have our most earnest consideration.



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THE SECRETARY: Mr. Chairman, the next submission is the Board of Evangelism and Social Service of the United Church of Canada, and the Reverend Mutchmor will come forward and introduce his delegation and speak on behalf of the submission. It will be known as Exhibit No. 352.

--- EXHIBIT NO. 352: Submission of the Board of Evangelism and Social Service of the United Church of Canada.

SUBMISSION OF THE BOARD OF EVANGELISM
AND SOCIAL SERVICE OF THE UNITED
CHURCH OF CANADA

Appearances: Dr. H.C. Grant
Dr. William Service
Rev. M.C. Macdonald
Rev. J.R. Mutchmor

REV. MUTCHMOR: Mr. Chairman and members of the Commission: we are grateful for this opportunity to present a brief on behalf of the United Church of Canada. Our Chairman is Dr. H.C. Grant, an economist, and he will present the recommendations, sir, and then in discussion and questions and so on we will try to make our replies something along the lines of the suggestions under each name.

DR. GRANT: Mr. Chairman, in deference to the instructions which you have given in writing to our Committee, we have placed the larger part of our submission as factual material in an appendix, and we will not read that. We will read the summary recommendations and the general deductions from our appendix



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THE SECRETARY: Mr. Chairman, the
 next submission is the Board of Evangelism and Social
 Service of the United Church of Canada, and the
 Reverend Macdonald will come forward and introduce his
 delegation and speak on behalf of the submission.
 It will be known as Exhibit No. 222.

--- EXHIBIT NO. 222: Submission of the Board of
 Evangelism and Social Service
 of the United Church of Canada.

MEMBERS OF THE BOARD OF EVANGELISM
AND SOCIAL SERVICE OF THE UNITED
CHURCH OF CANADA

Appointees: Dr. H.C. Grant
 Rev. M.C. Macdonald

REV. HUICHONG: Mr. Chairman and

members of the Commission: we are grateful for this
 opportunity to present a brief on behalf of the United
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material.

1. The General Council of The United Church of Canada supports the establishment of an integrated and comprehensive contributory National Health Insurance program.

2. The United Church of Canada is scripturally enjoined to consider health as a social concern and thus concerned has built its own program of health and welfare on the principle that the strong must bear some of the burdens of the weak.

3. Considering the relatively satisfactory provisions for all aspects of medical care now available to a large percentage of the population, we firmly believe that it is the most immediate and pressing duty of our society to meet more adequately the needs of our citizens who, by reasons of isolation, low income or age, are receiving sub-standard medical care.

4. It is submitted that amelioration of the plight of the chronically ill is a matter of major importance which cannot be overlooked in the consideration of a National Health Service Program.

5. The United Church has long stressed and now re-affirms the serious nature of alcoholism as of major importance in any examination of Health Service needs.

6. It is recommended that adequately trained chaplains be appointed to Hospitals, particularly Mental Hospitals, and recognized on all counts as part of the healing service personnel of the staff.



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Grant

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4 7. It is suggested that one of the
5 most needed and most effective kinds of Health
6 Insurance can be provided through health education of
7 the public. We respectfully urge the Commission to
8 guide the nation in the proper direction in this area
9 of health services.

10 8. The United Church has willingly
11 assisted in obtaining a larger measure of co-operative
12 and co-ordinated effort with governmental bodies and
13 voluntary organizations in specific areas of health
14 and welfare - e.g. Hospitals, Nurses' Outpost Stations,
15 Homes for Elderly Persons, and work with Indians. The
16 United Church will welcome recommendations from the
17 Commission which, if acted upon, will achieve still
18 more effective co-ordination of effort and more effi-
19 cient use of resources.

20 THE CHAIRMAN: Thank you, Dr. Grant.
21 Now, do you wish to make any observations or general
22 observations, or development of your recommendations
23 at this time?

24 DR. GRANT: Well, I think these are
25 developed in the next few pages of our brief, Mr.
26 Chairman, unless you would like to have it otherwise
27 for your purposes.

28 THE CHAIRMAN: Well, whichever way.
29 I don't know whether you wish to go ahead reading, or
30 whether you wish to develop it by way of general
discussion.

DR. GRANT: Well, I am in the hands
of your Commission, sir.



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7. It is suggested that one of the

most needed and most effective kind of health insurance can be provided through health education of the public. We respectfully urge the Commission to guide the nation in the proper direction in this area of health services.

assisted in obtaining a larger measure of co-operative and co-ordinated effort with governmental bodies and voluntary organizations in specific areas of health and welfare - e.g. Hospitals, Nurses, Outpost Stations, United Nations will welcome recommendations from the Commission which, if acted upon, will achieve still more effective co-ordination of effort and more efficient use of resources.

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THE CHAIRMAN: Well, whichever way.

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MR. CHAIRMAN: Well, I am in the hands

of your Commission, sir.



Grant

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THE CHAIRMAN: Well, if you wish to read it it is quite satisfactory.

DR. GRANT: I would thank you if we could.

THE CHAIRMAN: Very well.

DR. GRANT: The General Council of The United Church of Canada has affirmed and re-affirmed its position in favour of a National Health Insurance Plan for Canada. In 1952 the General Council resolved in part 3 of a resolution on Health Insurance that the Council "urge all responsible governmental authorities in co-operation with the medical, dental, nursing and related professions to move as quickly as possible to the establishment of an integrated and contributory National Health Insurance program." In 1954 this position was re-affirmed and in September 1960 the General Council, meeting in Edmonton, resolved to "urge the Federal Government in co-operation with the medical, dental, nursing, pharmaceutical and related professions, to establish a comprehensive national health insurance program." (For full text of resolutions, see preceding pages.)

The membership of the General Council of The United Church of Canada, consists of half ministerial and half lay representatives. Those who are members of the ministerial profession have never presumed to tell members of another profession how to do their work. Likewise, this brief is not an attempt by the professional servants of the Church to dictate to other professions. No effort was made in our General



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Council, nor is there any attempt in this brief to spell out procedures. We do not presume to advise governments about financing this proposed project of Health Services.

On the other hand, the United Church thinks it has both a right and a duty to submit a brief to indicate the relevance of Christian teaching about such principles as the duty of the strong to bear the burdens of the weak.

Our Communion is further of the opinion that the experience in pastoral work provides a basis from which findings and recommendations may be made.

The Christian Church has both an historic and immediate interest and concern. She has a doctrinal and a practical approach. She presents her views partly from her general teaching as she interprets the mind of Jesus Christ for man and society and partly from day-to-day experience.

The day-to-day experience is of a general and a particular kind. The general aspect as noted above, is pastoral visitation. This pastoral work in The United Church is done by some 3,346 ministers in 2,728 pastoral charges with 5,898 preaching points in all parts of Canada. It is undertaken in service to the 4,000,000 Canadians who regard the United Church as their religious Communion. Further, this ministerial pastoral work is supplemented in many ways by the pastoral work of several thousand lay members some of whom serve on a full-time basis.



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In the course of this varied pastoral work among people of every age and economic group much information about human needs, physical, mental and spiritual, is gained. It is not too much to say that Christian ministers of Communion such as The United Church of Canada more frequently visit in the houses of people than any other professional group.

GUIDING PRINCIPLES

This scriptural and doctrinal statement regarding health services can best begin with a presentation of the principles which guide the Church and underlie the particular judgments to be set forth.



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CONCLUSIONS

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4 The crucial consideration is that our
5 Lord Jesus Christ healed the sick. After all proper
6 allowances have been made for possible errors in the
7 record, it is beyond doubt that Jesus healed a variety
8 of diseases and disabilities. Twenty-six cases of
9 healing are reported. Jesus' motive was compassion for
10 the afflicted and the desire "that they may have life,
11 and have it abundantly". His acts of healing were a
12 part of his whole mission and served the same basic
13 purpose as his preaching and teaching.

14 In some instances healing seems to have
15 taken place through the awakening of an active faith
16 in the afflicted person, in other instances apart from
17 any such participation. Jesus used a variety of
18 "methods" including some that could be considered
19 "medical", though the results clearly flowed from a
20 power in himself rather than from the "methods" he
21 adopted. The individual found a loving attention
22 focussed upon him, and felt himself truly a person in
23 the presence of Jesus, as in the presence of God.
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25 There is a special interest in the
26 Lukan accounts of the healing miracles, since Luke
27 was himself a physician.

28 While there are those who stress
29 Jesus' apparent belief in a relationship between sin and
30 sickness - and we would accept this only in terms of sin
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4 health and in some instances "being saved" meant
5 specifically deliverance from disease or disability.

6 In Luke's gospel we read that Jesus
7 commissioned his twelve disciples and sent them forth
8 to preach, cure diseases and cast out demons. Later
9 he sent seventy other disciples in the same manner. In
10 Acts, Luke reports the continuance of the ministry of
11 healing in the Church after Jesus' death and
12 resurrection.

13 Throughout the centuries since Christ,
14 the Christian Church has had a continuing interest in
15 health as a part of its total concern for people and as
16 a necessary expression of the mind and spirit of its
17 Lord. It supports the work of healing by every
18 effective means and believes that there is a religious
19 significance in the whole ministry of health even when
20 it is carried on under "secular" auspices. (Although
21 broad philosophic reflections are beyond our present
22 scope, we would note the contemporary definition of
23 religion as a "dimension of depth" related to all of
24 life, springing from an attitude of "ultimate concern".
25 Paul Tillich) We particularly approve the movement
26 to consider health as a social concern; when sickness
27 or disability strikes is surely a time when the
28 individual stands most in need of the support and help
29 of his fellows, and to provide for treatment under a
30 comprehensive plan is one way in which the strong may
bear the burdens of the weak.

We observe with interest the trend to

mind and in Biblical usage the term "salvation" included health and in some instances "being saved" meant specifically deliverance from disease or disability. In Luke's gospel we read that Jesus commissioned his twelve disciples and sent them forth to preach, cure diseases and cast out demons. Later he sent seventy other disciples in the same manner. In Acts, Luke reports the continuance of the ministry of healing in the Church after Jesus' death and

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the Christian Church has had a continuing interest in health as a part of its total concern for people and as a necessary expression of the mind and spirit of its Lord. It supports the work of healing by every effective means and believes that there is a religious significance in the whole ministry of health even when it is carried on under "secular" auspices. (Although broad philosophic reflections are beyond our present scope, we would note the contemporary definition of religion as a "dimension of depth" related to all of life, springing from an attitude of "ultimate concern". Paul Tillich) We particularly approve the movement to consider health as a social concern; when sickness or disability strikes is surely a time when the individual stands most in need of the support and help of his fellows, and to provide for treatment under a comprehensive plan is one way in which the strong may bear the burdens of the weak.

We observe with interest the trend to



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4 think in terms of a total person, a unity of "body"
5 and "Mind", and we believe this to be in accord with
6 the Biblical conception of man, although the concepts
7 of "body" and "mind" will doubtless continue to be
8 used. We would see health in a broad perspective that
9 includes the meaning and purpose of life. The
10 significance of human existence is realized in ordered
11 and harmonious relationships, of a man with himself,
12 with other men and supremely with his God. We consider
13 the common origin of the terms "whole", "health" and
14 "Holiness" to be significant.

15 We believe that the Church has a large
16 responsibility for health along the lines already
17 noted: to give moral and spiritual support to the work
18 of healing; to promote concern for health and compassion
19 for the afflicted; to foster a warm supporting
20 fellowship among people in which prayer for the sick
21 is regarded as a duty and a privilege; to keep alive
22 an interest in the total meaning of life; to so minister
23 to men that they may live in or be restored to a right
24 relationship with themselves, with each other and with
25 God.

26 But what is the relationship of the
27 Church as an institution to health care by medical,
28 psychiatric and similar means? Here, it seems that a
29 large degree of flexibility is called for in the face
30 of varying situations and needs. Throughout the
centuries the Church has frequently pioneered in health
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and through its medical missionaries in areas of need at

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4 found at certain times that its enterprises can be best
5 administered apart from its own institutional structure.
6 Therefore, at any particular time the Church is likely
7 to be found expanding its ministry in some fields and
8 relinquishing its work in others. Still another pattern
9 of activity is a ministry in co-operation with other
10 agencies as, for example, where a hospital chaplain serves
11 as a member of the healing team. At the present time
12 various trends in the work of the United Church are
13 to be observed and will be referred to in greater detail
below.

14 III

15 THIS BRIEF'S RELATIONSHIP TO THE ROYAL
16 COMMISSION'S TERMS OF REFERENCE

17 This brief in its main part and
18 appendices will include considered comment and, at points,
19 findings and recommendations about "existing facilities
and the future need for Health Services."

20 The Brief will not provide comment
21 on constitutional questions; neither will it make
22 reference to such administrative questions as the relative
23 responsibilities of the Federal -vs- Provincial
24 Governments or the share of financial and other support
25 to be borne by municipal bodies, although in general the
26 Church would support smaller units of administration
27 as giving more emphasis to personal relationships and a
concern for the individual.

28 The brief will include material on the
29 "financial burden" imposed by illness. It will stress the
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need of further and more effective integration of services.

The main objective of the brief is to present observations based on experience in the following matters:

(1) Health Services needs of the handicapped with particular reference to:

(a) The geographically handicapped

(b) The economically handicapped

(c) They physically handicapped, and chiefly the elderly people

(2) Healing Ministry of the Christian Church.

(3) Health Education - Prevention of illness and some other related matters.

(4) The United Church's policy in her Hospital Services and care of Elderly Persons in Residential Homes, and self-contained units for single elderly persons and elderly couples.

(5) A reference to some health service needs of Indians.

(6) A reference to our Church's work on behalf of alcoholics.

(7) A statment on Responsible Parenthood.

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SOME AREAS OF NEED

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5 the demands of modern society. On more thought it is
6 evident, however, that many well-educated and normal
7 people are handicapped. For the purpose of this brief
8 reference is made to three groups: geographically,
9 economically and physically handicapped people.

10
11 The Geographically Handicapped:

12 In a day when Canada's population
13 movement is from the rural to the urban areas it is easy
14 to forget the tens of thousands of our nation's
15 individuals and families who live and work in isolated
16 places. This large segment of our population is to be
17 found in frontier mining and lumbering areas; in fishing
18 villages; on prairie farms, in coastal regions and other
19 parts of Canada far removed from the services of urban
20 centres. Indeed it is not necessary to go outside
21 such a settled section as Southern Ontario to locate
22 isolated sections in which medical services are non-
23 existent or at a minimum.

24 In a large Alberta farming district
25 where the United Church has a seven point charge, the
26 limited medical service is provided by one older medical
27 practitioner. In case of a serious illness and a night
28 call, this elderly doctor does not and should not be
29 expected to respond. The great need of the people here
30 may not be hospital care but visitation by a competent
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This kind of situation is to be found in
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several Newfoundland and East Coast villages, particularly in winter time. Existing medical services are inadequate and hospitalization alone does not meet the needs.

It is evident that this sort of demand for health services will continue. To meet it a more extensive medical service is required. The United Church believes such provision will be possible only under a national health services program.

The Economically Handicapped:

The United Church with its many pastoral charges in poorer urban areas, in dockland districts, and in communities of recently arrived immigrants is well aware of the many problems of Canada's multitude of low income families. With current stress on our mounting gross national product, our affluent and technological society, it is a simple but dangerous thing to lose sight of the poor.

Not everybody gets a fair share of the national income. The Dominion Bureau of Statistics states that for much of each calendar year almost 10 per cent of the labour force is unemployed. For those with jobs the average wage in 1959 was \$3,904.00. Four million Canadians, about two-thirds of the total gainfully employed persons, did not receive more than \$75.00 a week. The low income worker's take-home pay is around \$257.00 monthly. The net income of the average Canada is the lowest since "the dirty thirties."

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5 assistance or relief often benefit from free medical
6 services. Still, in the lower income groups many who
7 try to pay their way are burdened with medical bills.
8 A large proportion endure illness because they cannot
9 pay for medical services. Others find it impossible
10 to purchase prescribed drugs. (It should be recognized
11 here that many doctors have given a great deal of service
12 for which they knew they would never be paid.)

13 The urgent need in this general
14 situation to provide better health services can be
15 underscored by a variety of illustrations. Two will
16 suffice.

17 There is the burnt-out worker who, at
18 the age of sixty years is headed for the scrap heap.
19 At the time of his economic weakness, his need for
20 medical care is likely to be at a high level. He has
21 no insurance. He is short of money. He is ten years
22 from the Old Age Pension requirement - and pension
23 provisions for this category of worker are not uniform
24 throughout Canada. He does not want to beg. He dare
25 not steal. Society must provide an answer to this man
26 and his family because, by his labours as a low-income,
27 and likely an unskilled worker, he has undergirt our
28 way of life by many years of hard work in mill, mine,
29 factory, at sea, in the lumber camps, on big scale
30 construction.

31 Again there is the plight of the
32 non-union person and his family. Of these there are
33 many thousands, indeed a million or two who never had a



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3 fringe benefit. They have no medical card - no
4 guarantee of health services. They are penalized because
5 they never achieved bargaining power, but their health
6 services needs are many and acute.

7 The Physically Handicapped by Reason of Age:

8
9 The plight of the chronically ill
10 demands attention now. The need to provide relatively
11 inexpensive bed care for the many older people who do
12 not need much medical attention is an urgent one.
13 There are signs of progress, but the kind of provision
14 required cannot be made available short of a National
Health Service.

15 The United Church of Canada operates
16 18 Homes for Elderly Persons. Her ministers and lay
17 workers visit tens of thousands of senior citizens in
18 their own little humble abodes. I am sure the Commission
19 know that other churches than the United Church do much
20 more work than we do. The Jewish Church and the Catholic
21 Church do much work in realizing now the additional
22 problem of the older age group and the need for additional
care for elderly people, which is a terrific problem.

23 Even with the Old Age Pension and
24 probably a little in the way of private means, many an
25 elderly individual or married couple has little in the
26 way of extra current or capital funds. For many the
27 month's leeway is ten to twelve dollars. Their
28 penury is made public as they shop at a groceteria. A
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lot to be run up on the money machine, the cash register.
Not much leeway left for health services.

The United Church strongly recommends that there be a better deal for the elderly Canadian. His or her chief need is a more adequate and available program of health services. Much credit in this regard is due the medical profession for increasing interest in geriatrics. The need, however, is money to finance a well planned program of health services.

The Church has a concern, too, for the chronically ill of all ages. Probably because cases of chronic illness are more rare among the young and middle age, when these cases do exist there is often no place for them except in institutions for elderly people, and these institutions do not meet their need either physically or psychologically.

V

THE HEALING MINISTRY OF THE CHRISTIAN CHURCH

The earlier statement on New Testament teaching sets out the divine imperative to the Church to do a pastoral work of a varied kind to meet human need at the physical, mental and spiritual level.

As modern medicine continues to be both an art and a science, it is natural and right that the contribution of the Church should be chiefly related to the art of medicine. Here the relation of health, wholeness and holiness is both apparent and creative.

As pointed out earlier in this part of the brief and supported in the appendix, the United



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7 general service. This form of ministry to individuals
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9 established and too generally known to require further
10 elaboration. In assessing Canada's Health Services needs,
11 however, the United Church would offer to carry her
12 share of this ministry outside her structure by providing
13 such services as counselling. In this kind of work she
14 would plan to engage trained medical and psychiatric
15 personnel so that a clinic in a downtown or inner city
16 area would render an effective health services ministry.

17 The more specific aspects of the
18 Church's healing ministry would include some now being
19 undertaken and others to be attempted. The close
20 relation of a hospital chaplain or chaplains and a
21 hospital's medical staff is described in the appendix.
22 The United Church's policy to appoint well trained
23 hospital chaplains on a full-time basis will continue and
24 work thus approved will be increased.

25 Similar appointments are needed to the
26 staffs of Mental Hospitals. In this newer field need is
27 recognized for an authoritative and representative
28 body, such as the Canadian Council of Churches, to
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4 and adequate salaries not unlike those of medical staff
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6 Research into the relation of spiritual
7 and medical aids to healing is greatly needed. As our
8 society becomes more pluralistic and as tensions
9 multiple there is need to understand in a more complete
10 way and more deeply the strains and worries of life
11 out of which not a few serious functional disorders
12 issue. Inter-professional consultation of physicians
13 and clergy would be most desirable; also conferences
14 involving doctors, ministers and other church workers,
15 social workers, nutritionists and others, integrating
16 their services in the treatment of the whole person.

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HEALTH EDUCATION OF THE PUBLIC

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In our society, personal and public assistance to the physically blind is seldom denied. Unfortunately, adequate assistance is not provided for those of us whose attitudes and practices in the prevention of disease are blinded by ignorance or prejudice. These attitudes and practices are deeply embedded in our folkways and mores and some of our existing culture patterns, particularly those associated with our consuming habits as moulded by the medicine men of Madison Avenue.

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It is not at all easy for Departments of Public Health and the voluntary efforts of the organized medical profession to effect worthwhile change in our individual mode of living. In a less complex age the family doctor was indeed a health educator. Few of us now have the privilege of being influenced by such a benign dictator. As laymen we may be pardoned if we express some concern lest the dramatic achievements in the cure of disease and the treatment of accidents do little, if anything, to reduce the already heavy burden on the physician's time and the number of hospital beds needed.

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Fund-raising campaigns associated with a specific disease or handicap deserve and receive widespread public financial support. The preventive activities of governmental departments of health, and the departments of public health in the medical faculties of our universities, receive, we believe, too little public recognition. Likewise, those non-governmental organizations which are primarily interested in health education, such as the Red Cross, the St. John Ambulance Association and the



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Health-saving campaigns associated with a specific disease or handicap, nerve and muscle weakness, should include financial support. The preventive activities of governmental departments of health, and the departments of public health in the medical faculties of our universities, receive, we believe, too little public recognition. Likewise, these non-governmental organizations which are vitally interested in health education, such as the Red Cross, the St. John Ambulance Association and the



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Health League of Canada which have worked, we believe, most effectively within the limits of their financial resources, have relatively little financial resources to work with.

As a church and as churchmen we do not absolve ourselves from criticism that we have paid relatively too much attention to the consequences rather than to the causes of personal distress. We, like others, have also been too little concerned with the whole man.

Returns from our surveys as given more fully in Appendix VII, show the need of education for mothers in nutrition and the care of children and for the public in general in making use of existing public health services. The Church endorses a physical fitness program based on creating conditions of health and well being for everyone rather than the promotion of professional sports. And we would note that the Church is carrying on some very practical health education in its regular programs with its youth groups.

AREAS OF CO-ORDINATION

Hospitals, Homes, Outpost Stations:

The United Church stands ready to assist through a larger measure of co-ordination of her work in hospitals, nurses' outpost stations and Homes for Elderly Persons, with the work of other voluntary bodies in these general fields of health and welfare. The same support for co-ordination in our Communion's three Homes for Unwed Mothers and our pilot projects for Alcoholics' Hostels would also be assured.



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Localities, Areas, Pilot Stations:

The United Church stands ready to assist through a loan or assurance of co-ordination of her already present, with the work of other voluntary bodies in these general fields of health and welfare. The same support for co-ordination in our Dominion's three Homes for Jewish Mothers and our pilot projects for Alcoholics' hostels would also be assured.



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It would seem advantageous in every way if a larger measure of uniformity in administration at the provincial level could be effected. This need can be illustrated in regard to bed care for the elderly who must be in bed but who do not require much medical attention.

Such care in some provinces is administered in accord with the policy of a Welfare Department. In another province oversight is given by a Health Department. A larger measure of uniformity including uniformity or grants in aid, both current and capital is desirable.

As noted earlier, the need to provide more adequately for elderly persons who are ill is an exceedingly urgent matter. Many of these fellow citizens are alone. Not a few are frightened. Some become mentally ill from worry - needless worry. The plight of the elderly persons who are ill is a sad and sorry one.

Again hospital and clinical facilities for isolated areas, described in more detail in the appendices, is a considerable need. Here reference is made to the suggestions of Dr. Jackson of Saskatoon (Appendix II, 3.(3)). Dr. Jackson claims that a family's financial outlay for travel, hotel accommodation, baby sitter to take a mother's place - often add up to more than a medical bill. His suggestion about underwriting or at least providing a part subsidy to meet such expenditures is worth of consideration by the Commission.

Work with Indians:

The Christian Churches and the Federal

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is desirable.

As noted earlier, the need to provide

some adequately for elderly persons who are ill is an extremely urgent matter. Many of these fellow citizens

are alone. Not a few are frightened. Some become

mentally ill from worry - needless worry. The right of

the elderly persons who are ill is a sad and sorry one.

Again hospital and clinical facilities

for isolated areas, described in some detail in the

report, is a considerable task. Some reference is

made to the suggestion of Mr. Jackson of Saskatoon

(Appendix II, 2. (c)). Mr. Jackson claims that a family's

financial outlay for travel, hotel accommodation, baby

sitter to take a mother's place - often add up to more

than a medical bill. His suggestion about undertaking

or at least providing a part subsidy to meet such

expenditures is worth of consideration by the Commission.

With the Commission:



Grant 12005

Government have a long established and close relationship in providing education and health services for Indians. (See Appendix V) It is sufficient here to stress the value of the health services of church operated hospitals and outpost clinics for Indians particularly in the Province of British Columbia where doctors from church hospitals make regular visits to neighbouring Indian settlements.

The United Church strongly supports endeavours by the Department of Indian Affairs to integrate the Indian population with other Canadians, not only in health services but in schools and community life. The United Church has provided boarding homes for Indian children of high school age so that they can attend the high schools at Teulon, Manitoba and Prince Rupert in British Columbia. And the Church has established Friendship Centres in Vancouver, Regina and Winnipeg to help Indian young adults to find employment and a place in the life of the community.

Care of Alcoholics:

Alcoholism now ranks high as a disease in Canada. Our purpose here is not to give views as to whether it is a sin, a disease, or an addiction. We stress the fact that The Alcohol and Drug Addiction Foundation of Ontario reported over 217,000 alcoholics in Canada in 1959, an increase of 9,000 over the previous year. Of this large total 80,000 are reported to be in Ontario. A more recent report from the Foundation states that:

About one-third of all Canadian adults

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Alcoholism

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states that:



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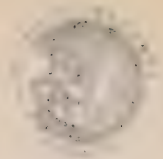
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3
4 abstain from all use of beer, wine and liquor. Most of
5 the other two-thirds - those who drink at least occasion-
6 ally - are not personally involved in "alcohol problems",
7 but a minority are. At least one adult Canadian in 50
8 (one in 33 who drink) is an alcoholic. This is more
9 people, for example, than have T.B. Even occasional
10 intoxication produces more court convictions than any
11 other offence except traffic offences. Some of these
12 people are simply irresponsible, others are actually ill.
13 They come from all classes of society and their behaviour
14 is costly not only to themselves, but also to their
15 families and friends, to their employers and fellow-
16 workers, to the public in general.

17 On the average each alcoholic causes
18 concern and often hurt and suffering to five or six other
19 persons: husband to wife and children; mother to husband
20 and children; children to parents and so on.

21 The rate of alcoholism is increasing
22 in spite of the good work of established alcoholism
23 research foundations. Surely it is a serious problem
24 and deserving the attention of this Royal Commission.

25 The United Church of Canada stresses
26 both the legislative and educational approach to this
27 subject. Recently our Communion published a major report
28 on Temperance, the result of three years' research and
29 study.

30 Our Church cooperates with many A.A.
groups. We have begun some hostels or half-way house
projects for alcoholics. We are deeply concerned with
several aspects of the highly organized Liquor Trade and



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particularly with its powerful control and promotion of its products.

Our concern at this point is to stress the serious nature of alcoholism as a major subject in the general field of health services needs, and strongly to recommend that the Royal Commission go thoroughly into the question of health services needs on this front.

It is the view of the United Church that currently established alcoholism research foundations in several provinces require far more provincial support and, further, that major research into alcoholism should be undertaken by a federal government agency. Such an agency could do excellent work on its own and also co-ordinate provincial research undertakings.

RESPONSIBLE PARENTHOOD

At a meeting held last Fall under the direction of the Canadian Council of Churches on "Church and Family Life", the Department of Christian Education of the Canadian Council of Churches passed a resolution "That the Canadian Council of Churches express its interest in the formation of a Planned Parenthood Federation in Canada, to provide adequate information and help to married couples who are at present unable to afford medical advice, and to work with the Planned Parenthood World Organization to assist undeveloped countries to receive similar help."

Since its Seventh General Council in 1936, the United Church has affirmed its belief in the importance of voluntary parenthood as the wise course in Christian marriage, and has welcomed the powerful



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RESPONSES AND FURTHER THOUGHT

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Grant 12008

reinforcement of this view expressed by the Bishops of the Anglican Church in the Lambeth Conference of 1958. The Nineteenth General Council held at Edmonton in 1960 associated itself with the relevant passage of the Lambeth Conference statement:

"That the responsibility for deciding upon the number and frequency of children has been laid by God upon the consciences of parents everywhere: that this planning in such ways as are mutually acceptable to husband and wife in Christian conscience, is a right and important factor in Christian family life and should be the result of positive choice before God."

It is the belief of the United Church that it is not only in the limitation of the numbers of children that wise parenthood can be expressed, but also in giving consideration to the quality of life that parents can offer to their off-spring, for whom they are responsible. Amongst these qualitative aspects of family life health is basic, and because this is so, then true parental responsibility will lead to the use of such methods of family limitation as have been proved to safeguard the health of mothers and their children and to contribute to the harmony of the marital relationship. For this reason we suggest that family planning be included amongst the subjects for consideration in a national health service program.

The opportunity to present a statement to you has caused us to re-examine our Christian responsibilities and practices and if, in your wisdom you find that we have not met our responsibilities, or have accepted

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The opportunity to present a statement to you has caused us to re-examine our Christian responsibilities and practices and, in your wisdom you find that we have not met our responsibilities, or have sought



Grant 12009

them in an inadequate manner, or have assumed responsibilities which we should not have assumed, may we now say that The United Church of Canada will welcome your views and will give them earnest consideration for positive action.

THE CHAIRMAN: Thank you, Dr. Grant. Just by way of observation on your closing paragraph, I would say now what I have had occasion to say before, that we are a body to hear and absorb, not a body to inform or make suggestions to those who appear before us or educate those before us. We are here to be educated by you and, therefore, there is to be no thought of accepting the invitation contained in this last paragraph.

DR. GRANT: I think you misconstrued the invitation, we are saying that if in your recommendations and findings ---

THE CHAIRMAN: Ultimately?

DR. GRANT: Ultimately, we are open to criticism like everybody else in terms of our inadequacies and we try to cooperate with our service as it is within our power.

THE CHAIRMAN: But even within that context we would not be critical to anyone who appeared before us.

DR. GRANT: I am sure of that.

THE CHAIRMAN: Your submission read in whole perhaps limits a degree of discussion that might have followed otherwise, but there are still some elements that I think we would like to have, perhaps, some further explanation of. With your cooperation perhaps we would



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4 like to investigate some of these a little further. From
5 the premise that you postulate on Page 8, the concluding
6 sentence in that first paragraph, you refer to the
7 resolution of General Council in 1952 urging upon all
8 responsible Government authorities, and so forth, and
9 then you go on to say that you do not necessarily concern
10 yourselves with the constitutional aspects of the problem.
11 That is something which I think we quite all easily
12 accept, because the details, the spelling out of procedure
13 is something apart from a discussion of principle. But,
14 in that resolution of General Council in 1952, you urge
15 Government to move as quickly as possible to the establish-
16 ment of an integrated and contributory national health
17 insurance program. Is it implicit in that resolution
18 that you foresee a premium system, a contribution from
19 the individual towards any program however it might be
20 worked out in detail?

21 REV. MUTCHMOR: We thought this word
22 "contributory" might come up in the series of questions.

23 THE CHAIRMAN: I think it does,
24 because it has been used in various ways by various people
25 and it is because of that I would like to have your
26 views, what you mean by the word.

27 REV. MUTCHMOR: We have been studying
28 this report of Prof. Robert M. Clarke which you will
29 know, the two volumes on economic security for the aged,
30 and we find some three pages here setting out the meaning
of "contributory pension", Pages 50 to 52 inclusive. We
would answer in terms of these pages. We think that
this is a very clear statement of that term "contributory".



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Mutchmor

12011

MR/dpw

THE CHAIRMAN: Would you care to put in capsule form what Dr. Clark said there?

REV. MUTCHMOR: Well now, these capsules, they may be all right in medicine but I don't know about them in commenting on a brief, sir. It's a pretty broad word but we mean that the people of Canada individually would know that they are paying for this proposed national plan.

THE CHAIRMAN: Dr. Clark's report was what, 1958?

REV. MUTCHMOR: 1959. It's dated February, 1959.

THE CHAIRMAN: The resolution is 1952.

REV. MUTCHMOR: Yes. Well, I suppose at that time we took it pretty much from the British system; being a contributory system we remembered that in Britain they got relief and contributory support mixed up and had the May Commission and Britain went off the gold standard because she confused relief, as such, with out-and-out contributory plan.

Having that lesson that Britain learned in mind, we thought it should be contributory in the sense it would be paid for. It would be insurance. It would not be relief.

THE CHAIRMAN: We have to expect it has got to be paid for unless somebody is going to get it for nothing, unless we are going to have some outside nation provide us with the funds. But how should the contribution be made? Are you saying it should be done solely through taxes or through a



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personal premium or through a combination of both?

REV. MUTCHMOR: Well, in 1952, we hadn't got that far in our thinking. I think pretty much in terms of the hospitalization plan. Deduction at the source, payroll.

THE CHAIRMAN: In what province, Dr. Mutchmor? We have three systems, three provincial systems of hospitalization in Canada. That is part of our problem, you see?

REV. MUTCHMOR: I know.

DR. GRANT: Mr. Chairman, I may add that I was concerned about this terminology in the Commission and as an economist and Chairman of this group I attempted to find out what the Council had in mind and I think they were just as confused as Lord Beveridge and the Senate Commission. They didn't know and I would, as a member of the Church, and as a member of this Commission, I would say that the Church used the term in a general sense without attempting to define a very significant difference. That is, whether it comes out of the general tax levy or is contributory in the sense that a person is levied in some way or other.

THE CHAIRMAN: In whole or in part?

DR. GRANT: Exactly, and I don't think, in asking questions of various people, that that part of the statement was really considered in its technical sense. Nor would I say that the Church did commit itself in the technical sense that you are now asking for an opinion.

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Grant

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3 THE CHAIRMAN: I thought I was asking that
4 not in a technical but in a very practical way.
5 However, what may be practical to me may be technical
6 to you.

7 DR. SERVICE: I wonder, sir, if this
8 would sum it up: that in my thinking in terms of this,
9 the contributory is laid on one side rather than a
10 completely tax-supported system. In other words, the
11 type of insurance system - I think you have received
12 several different types of answers from the panel here
13 which indicate simply what Dr. Grant has said. We
14 have no answer.

15 THE CHAIRMAN: And from other organiza-
16 tions.

17 REV. MUTCHMOR: We would like to
18 point out, sir, I am associated with business for
19 quite a long time, that we are quite concerned that
20 individual Canadians experience individually their
21 payments.

22 Now, I do not want to cast any reflec-
23 tion on the unemployment insurance administration but
24 it is evident, in the past few years, that it has got
25 a little off the track in places due to the fact that
26 individuals think, Oh well, it's the country. It's
27 the Government. It's general funds and if they take
28 something that doesn't belong to them, there is nothing
29 immoral about it. We, as a Church ---

30 THE CHAIRMAN: Recognize individual
responsibility.

REV. MUTCHMOR: That is right. Common

REV. MURPHY: That is right. Common

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Mutchmor

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honesty. We don't want any chiselling.

THE CHAIRMAN: I think we would all be on common ground in that matter.

REV. MUTCHMOR: We think it's pretty important.

THE CHAIRMAN: You see, that takes us to the second aspect of this problem in which there may be some people who, regardless of how much they would like to accept their individual responsibility are unable to do it and for which the State or somebody - in the absence of any other agency, the State must make provision and then it becomes a question of identifying that segment of the population which cannot make any contribution by way of premium, by way of personal contribution to any health service.

Now, have you given any thought along that line? I mean, has your thinking progressed along that line to be able to answer the question as to how do we go about identifying that area?

REV. MUTCHMOR: Our Chairman may wish to answer that, he being an economist.

DR. GRANT: Mr. Chairman, I would say that as far as the Council is concerned, as far as our terms of reference representing the Council, we have not, and it would be impossible for us to represent a consensus of opinion of the United Church on this question which is a very important one.

THE CHAIRMAN: If the matter has not received consideration, it would be presumptuous to either ask or expect the answer. Now, whether you may



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3 be able to give us some assistance on what is again
4 an integral part of the second phase which is identifying
5 the segment of the population for which the State must
6 assume complete responsibility in the way of payment
7 by whatever form it might be done; whether what has
8 been usually called the employment of a means test is
9 or is not a defensible or practical mechanism.

10 DR. GRANT: Could you approach it from
11 another way, Mr. Chairman? I think what the Church -
12 I think there is a consensus of opinion and we can
13 represent it, that there should be provided a minimum
14 of national health services to all people of Canada
15 regardless of their location or their income or their
16 ability to pay.

17 There are certain services which a
18 comprehensive national service, which is our primary
19 concern, could provide as a minimum, in our opinion,
20 across Canada without any means test. That is to say,
21 that by the support of whatever would be the plan of
22 medical service, the minimum of medical service in
23 transportation to available services, which are
24 available to a lucky person like myself, that there
25 should be no means test to provide a minimum of funda-
26 mental services to preserve health.

27 Wherever they are lacking it is the
28 duty of the three levels of government, by whatever
29 means they may work out, so that the resident of Spruce
30 Cove in Newfoundland in a fishing village has at least
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From then on you get into a debatable area which is now almost political, as to whether it may be contributory, and so on. The Church's main concern is with that provision.

THE CHAIRMAN: Nobody should go without?

DR. GRANT: That is right. That is where we have pioneered. That is where the Church is now pioneering in the elderly. Neither governments or municipalities, fraternal lodges and churches, but this problem is growing now with the age grouping. Can the denominations of voluntary agencies provide these services as a minimum now? We would say the minimum should be provided by society. We will continue to make our contribution if it isn't provided and meet the challenge.

I think there are two concepts, in our mind, that are unanimous. That is, as opposed to what might be called health insurance and total health services we are mainly concerned with a minimum of decent health service, hospitalization, family care and these things, wherever the citizen may reside as a right as a member of the community and if we have to be taxed to provide that in general tax levy, yes.

When you get into the pure aspects of prepaid medical care, we cannot speak as a Church. We are too diverse, but we can speak as a Church, I think, on the minimum of health service.

THE CHAIRMAN: Well, your resolution, which you quote here, is to move as quickly as possible to the establishment of an integrated and contributory

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be taxed to provide that is general tax levy, yes.

When you get into the pure aspects

of prepaid medical care, we cannot speak as a Church.

We are not divorced, but we can speak as a Church. I

think, on the minimum of health services

THE CHAIRMAN: Well, your resolution,

which you state here, is in more or less as possible

to the establishment of an integrated and contributory



Grant

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national health insurance program. I take it that the word "insurance" was not included by accident?

DR. GRANT: No.

THE CHAIRMAN: It is there.

DR. GRANT: That is right. It is there.

THE CHAIRMAN: The way you would express it now, the resolution would read:

"To the establishment of an integrated minimum national health program."?

DR. GRANT: As far as this brief is concerned of this Committee, that is our presentation. The other stands in itself.

REV. MUTCHMOR: We realize, sir, that you have heard a great many briefs. You have a great deal of information.

THE CHAIRMAN: Oh, indeed.

REV. MUTCHMOR: On the chronically ill, but if there is, in the limited time we have, a great deal of concern about the elderly chronically ill who apparently do not need a considerable amount of medical attention but who do need the bed care and our larger urban areas, where we have our homes and where we, in our pastoral work with our Church, have close contact with many of these elderly people, we are finding it extremely hard for them to get into a hospital bed for their final illness and we have, from our ministers and many other observations, the view which doubtless has been brought before you that many of the so-called nursing homes are not adequate and

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THE CHAIRMAN: It is there.

DR. GRANT: That is right. It is

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our ministers and many other observations, the view

which doubtless has been brought before you that many

of the so-called nursing homes are not adequate and



Mutchmor

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this is a very urgent matter.

THE CHAIRMAN: I think I might say this: that we have had very strong representations from one end of Canada to the other and from many organizations and from many ministers of the United Church appearing with delegations and various other clergymen quite frequently on the need for these places that you speak of.

In another area, in connection with the mentally ill, perhaps the most neglected field of health service in Canada today and with the care of the aged rising perhaps next, although great emphasis is laid on the deficiencies that exist in connection with crippled children and retarded children and that kind of thing and we have asked the question periodically.

I will put it to you just so you may follow the thinking as to whether, in the situation in Canada today, perhaps too much stress is not being placed on providing physician services more or less in priority - additional physician services more or less in priority to these greater needs of the aged, the infirm, the crippled and the mentally ill. That is where this matter of priority lies.

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This is one reason why we have asked for more co-ordination, because some provinces, in fact this Province of Ontario puts this kind of thing under its welfare department, and its grant is quite low. In Quebec we think we are going to get as much as \$6.00 a day, which we think we could get by on.

We understand that the non-active case of an elderly person does not need to be in an entirely organized hospital. It could be looked after by a church or an infirmary, which we are equipped to do.

THE CHAIRMAN: At a cost far below what Hospital Services can do it for?

DR. MUTCHMOR: Yes, but in Ontario it is a fact that this goes under welfare in this province, not under health, and we might get say \$2.10 a day, and we couldn't operate for that.

THE CHAIRMAN: Yes, I think we do better than that in our province.

DR. SERVICE: This is an area that we look to you for aid in clarification across the country. It seems that this elderly type of patient, or person, is caught, for instance in Ontario, between these two departments, the welfare and the O.H.S.C., and quite frequently there seems to be the attitude of shifting the responsibility this way or that. In other words, it is very difficult in any individual patient in certain categories to say specifically whose responsibilities they are, and these unfortunate old people are therefore caught with not enough accommodation, and the question also who is really to look after them, and I think we feel

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Mutchmor

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4 that clarification should be forthcoming in this
particular area.

5 THE CHAIRMAN: Then you come to the
6 area that Dr. Watson was stressing, of the isolated
7 person, whether it is on the coast of Newfoundland or in
8 the North West Territories, then it becomes a question
9 of by what means services may be subsidized, the persons
10 may be subsidized to render service in those areas.
11 We have had representations twice this week on that very
12 point that you have made this afternoon, about health
13 and welfare being separated, that there ought to be a
greater integration and co-operation between departments.

14 DR. MUTCHMOR: Are there not areas,
15 I mean places in Canada where that integration is already
16 taking place?

17 THE CHAIRMAN: Well, there are places
18 where it is not divided. I don't know if there has been
19 a division and an integration, but for the moment there
are areas where there is no division anyway.

20 COMMISSIONER BALTZAN: Just one thing
21 gentlemen. Would you just please help me in my thinking
22 about this matter. When you say the General Council of
23 the United Church of Canada supports seven, eight, or
24 nine opinions such as you have said here, and that is
25 the consensus of the Council, how does that reflect on
26 say the congregations? Is that an expression of opinion
of the congregations, of the individuals?

27 THE CHAIRMAN: Well, I suppose it is
28 built up. I mean to say it is a delegated authority.

29 COMMISSIONER BALTZAN: I do say in
30

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3 innocence, I want to know when a statement is made say
4 in the United Church of Canada, whether it represents
5 all church-goers, or whether it is ---

6 THE CHAIRMAN: You won't get them all
7 together till Gabriel's horn blows.

8 DR. MUTCHMOR: Well, we say that ours
9 is a consilier church, which is governed by its Courts,
10 in our case the highest Court is the Council, which
11 meets every two years. You put your finger on a point,
12 namely of authority and consensus, and I think the best
13 we could do by way of answer is to say that a matter of
14 this kind is not brought to our highest Court without
15 a good deal of previous study. That when we make this
16 kind of study we make it across the country with
17 representative and regional committees, but even when
18 that is said, still with four million ---

19 COMMISSIONER BALTZAN: That is just
20 the point.

21 DR. MUTCHMOR: We favour the nationaliza-
22 tion of the liquor trade. That does not say that four
23 million church members do.

24 REV. MACDONALD: But these Courts are
25 made up of the elected representatives, and to that
26 degree they would by and large reflect the opinion of
27 the membership of the Church.

28 COMMISSIONER BALTZAN: I think you
29 have helped me understand.

30 THE CHAIRMAN: Thank you very much,
Dr. Mutchmor and gentlemen. This is a valuable document,
not only in terms of the technical information and the



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3 factual information in the appendix, but for the state-
4 ment of principles, which we are very pleased to have.

5 DR. MUTCHMOR: Thank you very much sir.

6 THE SECRETARY: Mr. Chairman, the
7 next submission is that of Boys Village of Toronto,
8 to be known as exhibit number 353, and Mr. Fisher will
9 come forward to introduce his group and do a verbal
10 summary of the brief.

11 ---EXHIBIT NO. 353:

Submission of Boys Village
of Toronto.

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 ment of principles, which we are very pleased to have.

MR. MUTCHNER: Thank you very much sir.

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to be known as exhibit number 363, and Mr. [unclear] will

come forward to introduce his group and do a verbal

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Submission of Boys' Village
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SUBMISSION OF
BOYS VILLAGE OF TORONTO

APPEARANCES: Mr. Gordon Fisher
Mr. Horace Brown
Mr. David Barber
Mr. Robert Shaw

MR. FISHER: Mr. Chairman, Madam and Commissioners: I am the Chairman and President of Boys Village, and I am accompanied by Mr. David Barber, our Vice-President; Mr. Robert Shaw, our Executive Director. Mr. Shaw has a Bachelor of Science degree, Bachelor of Divinity, and a social worker degree, and is largely responsible for preparing our brief, which our Board has approved and I have signed.

First I would like to thank you for the opportunity of coming before you today. Also I would like to express our admiration, having looked at your schedule of appearances, of the pace which you have set yourself.

Boys Village is an organization which came into being, and exists now, to serve emotionally disturbed children.

Mr. Shaw has just written Mr. Brown, who is beside us on my right. Mr. Brown is here, and has joined us, but was going to appear after us for the Department of Public Welfare of the City of Toronto, but was asked to join us today.

THE CHAIRMAN: We are happy to have Mr. Brown here in both capacities.



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Fisher

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4 MR. FISHER: I was saying that Boys
5 Village is an organization which was created, and exists
6 now, to serve emotionally disturbed boys. We think that
7 our brief, and I won't quote from it at this stage,
8 documents the size and the need for this treatment of
9 emotionally disturbed children. I think the brief goes
10 even further than that, and proves that the need is
11 far beyond our Boys Village capacity to meet it.

12 Our concern today is only partly to
13 back up this proof of the need, but also to outline and
14 emphasize in the form of summarizing our summary on
15 certain points which are difficulties which we find in
16 pursuing the service that we do.

17 There is a summary of the points and recommenda-
18 tions that we make which appears after page 4 in our brief.
19 I won't read them. I will go even farther, and summarize
20 the summary, and take, I hope, only a few minutes in doing
21 so.

22 THE CHAIRMAN: No, you take as much
23 time as you may require to spell out what you want us
24 to hear.

25 MR. FISHER: Thank you sir. The
26 difficulties we face group themselves under two main
27 headings. The first of these is that in the treatment
28 of emotional disturbance in children there is a lack
29 of definition, a lack of standards, and a lack of
30 co-ordination in the field. I will quote from page 6
of the brief:

"One of the basic problems in the
field of service for emotionally disturbed children is

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"One of the basic problems in the

field of service for emotionally disturbed children is



Fisher

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4 that literally every organization concerned with
5 children is assuming some function relative to the
6 emotionally disturbed child. This function may be
7 marginal in the sense of referral, it may be treatment
8 in the sense of offering in-patient therapy, it may
9 be diagnostic in the sense of the evaluating function
of a clinic".

10 And further, on page 7, and as an
11 example only:

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12 "A problem of the co-ordination of
13 services for the emotionally disturbed child is also
14 seen within the departments of Provincial Government.
15 The following departments of the Government of Ontario
16 have some specific functions regarding the emotionally
disturbed child".

17 I should add here that our service
18 exists in Toronto in the Province of Ontario, and the
19 attempts to supply the demands of this service only
20 apply to the Province of Ontario, and our recommendations
apply only to the Province of Ontario.

21 We have to deal with the Attorney-
22 General's department through the Probation Service and
23 Juvenile Courts, the Ontario Department of Education
24 through the Special Education branch; the Department of
25 Reform Institutions through the Training Schools branch;
26 the Department of Health through the Mental Health
27 Division; and the Department of Welfare through the
Charitable Institutions Act and the Child Welfare Act.

28 One of our recommendations, number 5,
29 is that the various departments of Provincial Government
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Fisher

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4 must work toward a greater co-ordination of their
5 responsibilities on behalf of the emotionally disturbed
6 child.

7 THE CHAIRMAN: In connection with that
8 statement, are you finding that there is inefficiency,
9 or time lost, or what?

10 MR. FISHER: Well, time lost, yes, and
11 a lack of co-ordination, yes. I would hesitate to say
12 inefficiency. It makes us inefficient, let us put it
13 that way.

14 THE CHAIRMAN: It makes it more
15 difficult for you to accomplish what you wish?

16 MR. FISHER: Certainly, yes. Another
17 of our recommendations has to do with this same problem
18 of co-ordination and standard setting. That is number
19 11. We recommend that the Canadian Mental Health
20 Association undertake the task of setting standards for
21 treatment services for emotionally disturbed children.
22 We feel that this organization should also stimulate
23 public interest in the development of local treatment
24 centres.

25 There are no standards now, and this
26 is definitely a problem to us. ~~This is the~~ first main
27 area that I want to emphasize, the lack of co-ordination
28 and standards.

29 The second main area is, naturally
30 enough, the question of finance. We have found that the
treatment of emotionally disturbed children is extremely
expensive. It is so because of the nature of the service
~~you~~ provide, which demands substantial time from a lot



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Fisher

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We have not been in business long enough to be able to claim that it would be impossible for the communities to support voluntarily the high costs that our service demands, but it is our guess that the community wouldn't support this voluntarily. We are recommending, as items numbers 12 and 13, governmental subsidies from the province covering both operating costs to the extent of 85% and capital grants up to 50%, or in some cases 75%.



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Fisher

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THE CHAIRMAN: Your recommendation doesn't restrict you to province. You added the word "province" now.

MR. FISHER: Well, we don't want to go any further than the limits placed on us by our own province, but I imagine the same would pertain elsewhere. We have no wish to come and be another group that cry subsidy. We are making these recommendations insofar as our finances are concerned because the Provincial Government has also accepted the costs that appear elsewhere in the community which result from emotionally disturbed children who are in hospitals, penal institutes, criminal courts and elsewhere. We feel that in our recommendations this may now be the cheapest way for the community to solve this problem.

I did say we wanted to be brief. I did want to emphasize these points from our brief, and we are here to answer any questions which occur out of the rest of our submission.

THE CHAIRMAN: You draw from the whole of the Province of Ontario?

MR. FISHER: We would like to; we are not now.

THE CHAIRMAN: Provided that you have the facilities and the budget?

MR. FISHER: That is right. The problem exists in the whole of Ontario. We are attempting to do a small bit. It is far beyond our capacity, but the recommendation we make is aimed at solving the whole of the problem in Ontario.



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Fisher

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3 THE CHAIRMAN: Have you been able to
4 estimate the number of children, emotionally disturbed
5 children in Ontario?

6 MR. FISHER: Our brief doesn't give
7 any figure. I think guestimate would probably be the
8 better word.

9 MR. SHAW: We have estimated that
10 there are a minimum of 1,000 children in the Province
11 of Ontario requiring intensive residential treatment
12 and 10 times that many requiring the out-patient type
13 of treatment. The figures being quoted from various
14 studies of the incidence of emotional disturbance
15 are largely two types; one based on clinical experience
16 in the number of referrals to clinics and the other
on school population.

17 It was reported by Dr. Sturgeon that
18 some communities are saying that up to 10% of school-
19 children show emotionally disturbed problems requiring
20 treatment. In a study quoted recently in Windsor,
21 the percentage of school-aged children is between 3
22 and 5%, and in Toronto it was reported a 5% figure
as the percentage of school-aged children emotionally
23 disturbed requiring treatment.

24 THE CHAIRMAN: Your age grouping,
what age do you accept for treatment?

25 MR. SHAW: Our age limits normally
26 are 10 to 13, but they will be expanded downwards or
27 upwards of our present age range.

28 THE CHAIRMAN: Which is the one that
29 ought to be served first, below 10 or above 13?
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THE CHAIRMAN: Have you been able to estimate the number of children, emotionally disturbed children in Ontario?

MR. FISHER: Our brief doesn't give any figure. I think estimate would probably be the better word.

MR. SHAW: We have estimated that there are a minimum of 1,000 children in the Province of Ontario requiring intensive residential treatment and 10 times that many requiring the out-patient type of treatment. The figures being quoted from various studies of the incidence of emotional disturbance are largely two types; one based on clinical experience in the number of referrals to clinics and the other on school population.

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4 MR. SHAW: In the long run the answer
5 is to reach these children soon enough, and that would
6 be with the child and the family and prevent a break-
7 down in the family. The sooner we reach these children
the more efficient job we can do.

8 THE CHAIRMAN: You say reach. That
9 means recognition of the disability?

10 MR. SHAW: Yes.

11 THE CHAIRMAN: What is the mechanism
12 for the recognition?

13 MR. SHAW: The referral sources at
14 this point are the Juvenile courts, the Children's Aid
15 Societies, the out-patient clinics, the Boards of
16 Education. In the long run the best detection source
17 is the schoolchildren between 5 and 13 who are seen
18 by people, and we think, in the long term, it should
be concentrated in the school program.

19 THE CHAIRMAN: What part does the
20 family physician play in this matter of recognition?

21 MR. SHAW: I think that the physician
22 could have the real opportunity to observe this. Our
23 problem is, if he observes it now, there are very few
24 resources to which he can turn, so we don't really
25 have a measure from the family physician's point of
view as to how many children there are, in fact, at
this time.

26 MR. FISHER: I was going to add to
27 that, sir, that our experience is that the manifestation
28 of the emotional disturbance doesn't always appear as
29 a medical problem but more often a problem in school or
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that, also, that our experience is that the manifestation of the emotional disturbance doesn't always appear as a medical problem but more often a problem in school or



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more often a problem of theft in the community or petty crime of that nature, and sometimes the family physician is the last to hear about it.

THE CHAIRMAN: Unless it was a case that was very pronounced?

MR. FISHER: Yes.

THE CHAIRMAN: But once the condition is accepted, then it is an illness?

MR. FISHER: Yes, certainly an illness.

THE CHAIRMAN: What is the situation in regard to it being recognized as an illness under the prepayment plans in Ontario; say, P.S.I., and so forth?

MR. FISHER: It is not.

THE CHAIRMAN: Not at all?

MR. FISHER: Not unless for some reason the physician sends the child to a hospital or a psychiatrist.

THE CHAIRMAN: I take it that as such the Boys' Institution is not recognized as a hospital which qualifies under the Hospital Commission?

MR. FISHER: No. We exist under The Charitable Institutions Act.

THE CHAIRMAN: Although you are actually treating an illness.

MR. FISHER: That is right.

THE CHAIRMAN: Have you tried to come under the institution recognized as a hospital? That would go a long way to solving your problem and would put 50% on the province and 50% on the Dominion.

MR. FISHER: Yes, that is probably the



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THE CHAIRMAN: What is the situation in
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THE CHAIRMAN: I take it that as soon
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MR. FISHER: Yes, that is probably the



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best solution, although I don't know of any other institution in Ontario which has been successful in doing what you suggest.

THE CHAIRMAN: What has been the obstacle? The non-recognition of an institution treating an illness as distinct from something else?

MR. FISHER: Yes, I think so. Again, the problem of the lack of definition we are faced with is exactly what the illness is and exactly what the best treatment for it is.

THE CHAIRMAN: If we get an illness we know of, cancer, we don't know what the treatment is for it at all, according to what we are told.

MR. FISHER: Yes.

THE CHAIRMAN: So the question of treatment may not be the deciding factor if the condition is recognized as an illness?

MR. FISHER: That is right.

MR. SHAW: The terms "mental illness" and "emotional disturbance", these terms are being used interchangeably now, we discover. This whole area provides a professional question as to what particular professions are competent in the treatment of the disturbance. The centres which have had the most experience with these types of children are those which combine the professions of medicine, psychiatry, psychology and social work.

In other words, we see the treatment of disturbance as that which is governed by a team of professionals, which includes at least three basic



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disciplines of psychiatry, psychology and social work and this lack still in the public mind, the lack of recognition of emotional disturbance, hampers the whole definition in the expansion of the work that needs to be done.

COMMISSIONER BALTZAN: Are you not really dealing with three contributory factors, one medical, the second, emotional and the third, environment?

MR. SHAW: Yes.

COMMISSIONER BALTZAN: These are interchangeable?

MR. SHAW: Yes, and they are entwined.

COMMISSIONER BALTZAN: And in the true medical sense they are not an illness of a medical nature?

MR. SHAW: Not always of a biological nature.

COMMISSIONER BALTZAN: Let's say pathological.

MR. SHAW: Yes, that is right.

MR. FISHER: The treatment of the problem when it exists that would appear to be most successful is not always the medical treatment.

COMMISSIONER BALTZAN: Would you elaborate a little further?

MR. FISHER: Yes. Our program is designed to take young boys away from their home, sometimes from the family, sometimes foster homes, and put them into a community-based residential care program

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3 where they are living in a house which the Boys'
4 Village runs. These boys are going to school in the
5 community, they are physically healthy and lead as
6 normal a life as we can allow them. This is what we
7 are trying to do, keep their living conditions as
8 normal as possible, so in this sense it is not a
9 medical treatment.

10 COMMISSIONER BALTZAN: A process of
11 reconditioning?

12 MR. FISHER: Yes.

13 THE CHAIRMAN: That almost describes
14 the newer mental treatment in England.

15 MR. FISHER: Yes, that is right.
16 It is not readily expected as coming under a normal
17 hospital plan that exists already.

18 COMMISSIONER STRACHAN: In the proper
19 recognition of the condition, would the teachers not
20 be the first who might observe it and are they given
21 any instruction along these lines in their normal
22 school at teachers' college?

23 MR. FISHER: I would hesitate to quote
24 a figure as to whether the problem of emotional distur-
25 bance manifested itself more in school than elsewhere.
26 It may be brought to his notice frequently as school
27 problems. Often the child does manifest problems at
28 school, and one of our jobs is to provide teaching
29 arrangements for children who can't get along in the
30 school, whose problem prevents them being in the school
in the community.

COMMISSIONER GIRARD: You would

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COMMISSIONER GLICK: You would



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advocate that the residential care of the child is really the child care centre, and is Boys' Village a child care centre in the sense that you describe it here as giving out-patient service, day care treatment and in-patient service?

MR. FISHER: Yes, that is right.

COMMISSIONER GIRARD: So you would want more organizations the same as you have now?

MR. FISHER: Yes, that and for our own objective to build up our organization to the size where the costs minimize themselves. There are certain fixed costs already with Boys' Village, and there is an optimum size. Boys' Village is below the optimum size.



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Fisher

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COMMISSIONER GIRARD: What is the optimum size?

MR. FISHER: We think that we should be able to handle 30 boys on an in-patient basis, houses that we run with about another 100 to 120 boys being treated on an out-patient basis. The ratio there is one that through our contact in the States now we have found to be a normal ratio between in-patient and out-patients.

COMMISSIONER GIRARD: If this is to be out-patient and day care it must necessarily be within an urban, in an urban centre so it would be acceptable to large population.

MR. FISHER: Yes, just by the nature of the fact a larger percentage of the population tend to be in cities, the larger number of boys that come to our attention live in cities. Simply in trying to create surroundings that are nearly as like as their home surroundings as possible, certainly the large volume, the large number of treatment centres should be in cities.

COMMISSIONER GIRARD: As to personnel, you speak about two different types that are lacking, one a special education teacher and the child care worker. We heard in another brief about the lack of child care workers, how would you describe this person in connection with your work?

MR. SHAW: Our function is to provide a child who has had disturbing adults in his life with a new environment, a therapeutic environment which means we have to have a child in close personal contact with people

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who are stable themselves and have an understanding of the child's needs and can interpret to the child what his problem is. These people who are in close personal contact with the child in residence are called child care workers.

COMMISSIONER GIRARD: How are they trained?

MR. SHAW: There is only one source in the Province of Ontario for in-service training at Thistletown Hospital, and that is for employees at Thistletown Hospital, the children's hospital. The University of Toronto and the Ontario Welfare Council have been exploring the training program for child care workers which would make available trained workers for the various programs in the Province. This has not been implemented largely because of their problem of finding a subsidization for the training program. In Boys Village we hire people with a BA degree and run the in-service training program for them within our own organization.

COMMISSIONER GIRARD: Thank you.

THE CHAIRMAN: Mr. Brown, do you wish to add something to this?

MR. BROWN: Mr. Chairman and Members of the Commission: While I will appear before you as a representative of the City of Toronto, I am appearing now as a parent. I admire the work done by Boys Village, I think it is among the most dedicated that I have encountered. However, it simply points out that our modern society is only beginning to understand this problem in the vaguest possible terms and is, in many respects, still trying to



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sweep it under the carpet. We no longer chain these children in dungeons but we relegate them to nothing, and that, in my humble opinion, is just as bad.

When I first became definitely interested in this problem, some seven or eight years ago, I found as Mr. Shaw said that they said there were some 1,000 of these emotionally disturbed children in the Province. However, the Windsor Survey knocked that into a cocked-hat by pointing out in the public schools in Windsor alone in a very short survey they found 365 of these emotionally disturbed children. I think these figures are correct. You know with retarded children they say there is one in every street, but I would venture to predict from my observation that there is one in every three or four homes where there is any kind of a large family. It used to be felt and still is felt by a great many people that this was a parental problem or a problem of environment in many respects, but recent surveys conducted by universities in the United States indicate that the parent is not the problem that was expected, that there are these children, that there are these "break-aways", if you want to call them, from the norm.

Now, how do you approach it? The emphasis is this, that today we can easily discover them, we are discovering them all the time but what do you do with them after you discover them? Outside of Boys Village and Thistletown and one other in the States there is nothing on the North American Continent that I can discover. There is a completely haphazard approach to the whole problem. One of the big problems is the



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Now, how do I know these things and how do I know the problem exists? I said a moment ago I was speaking as a parent and if there are any members of the press present, I hope they will treat the personal things I am going to say impersonally. In any case, I have an emotionally disturbed child. Now, I say child although he is today seventeen years of age. We have been aware of the problem since he was nine years of age although we were aware of it before. We were aware of it when he was about two years of age in some respects that here was someone different. I call them the "lost ones", the "forgotten ones". When he was about nine years old, I went to the family physician and I said "Is there anything wrong physically?" He said, "He is perfect physically". I said, "What about mentally?" He said, "You may have something there," and he arranged for an appointment with an internationally known psychiatrist. After about one and a half years of going to the psychiatrist he gave me the solemn verdict "You have a potential juvenile delinquent there". That was his answer.

By this time the boy was in trouble with the juvenile authorities, nothing wrong, the sort of thing people do, but he seemed to want to be caught with these things. I took him to the child guidance clinic and the child guidance clinic is a marvelous

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6 intensive tests lasting over about four to six weeks, I
7 have forgotten how long, the psychiatrist, and by the
8 way, this is interesting to note, one psychiatrist, I said,
9 "You are spending quite a lot of time with him, because
10 your appointment is for an hour but you are giving him
11 about an hour and a half". She said, "I never saw a
12 child in the long time that wanted to be helped as much
13 as your boy". These children want to be helped, they
14 know something is wrong. Finally the head psychiatrist
15 gave me the verdict and she said "Your boy has a very
16 deep emotional disturbance." I said, "What do I do?"
17 "Well, I don't know". "Should I send him to a private
18 school, would that be fair to the private school?" "No,
19 it would not." I said, "What am I going to do?" She
20 said, "That is your problem, Mr. Brown." She said, "I
21 will tell you one thing because I think you should know,
22 I cannot answer for the safety of your younger child if
23 he remains in the home." As I say, he was already in
24 trouble with the juvenile authorities. I got hold of my
25 friend Judge Stewart to discuss the problem and, by the
26 way, this is interesting to note, that Dr. Acheson who
27 was then in charge of the psychiatric clinic of the
28 Juvenile Court which was disbanded because they wanted
29 more money and which we finally got put back in through
30 the Parent Action League was on record as saying they
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institution in Toronto here. They gave him intensive tests and by this time he was nearing twelve. After the intensive tests lasting over about four to six weeks, I have forgotten how long, the psychiatrist, and by the way, this is interesting to note, one psychiatrist, I said, "You are spending quite a lot of time with him, because your appointment is for an hour but you are giving him about an hour and a half." She said, "I never saw a child in the long time that wanted to be helped as much as your boy". These children want to be helped, they know something is wrong. Finally the head psychiatrist gave me the verdict and she said "Your boy has a very deep emotional disturbance." I said, "What do I do?" "Well, I don't know", "Should I send him to a private school, would that be fair to the private school?" "No, it would not." I said, "What am I going to do?" She said, "That is your problem, Mr. Brown." She said, "I will tell you one thing because I think you should know, I cannot answer for the safety of your younger child if he remains in the home." As I say, he was already in trouble with the juvenile authorities. I got hold of my friend Judge Stewart to discuss the problem and, by the way, this is interesting to note, that Dr. Adelson who was then in charge of the psychiatric clinic of the Juvenile Court which was disbanded because they wanted more money and which was finally got put back in through the Parent Action League was on record as saying they sent around 30 to 35 of these emotionally disturbed children every year to training schools because there was no other place for them. These are boys and girls,



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do not forget and leave out the girls in this.

The only thing we could do was send the boy to the Cobourg Training School and he resisted for about four months and then he seemed to accept. As a matter of fact, he did very well, he took his entrance examination and got a 68% score on the year and they felt this had worked. I had gotten after them for psychiatric treatment and they have been very good and got a psychiatrist visiting the school fairly regularly and trying to do something for these boys. I will tell you, in this boys' school they even have retarded children, that is how bad things are.

When he got out of Cobourg everything was fine, he wrote the most beautiful letters and everything was fine for a couple of weeks. Then, he started again, he just could not cope with life. I will tell you what Dr. Rich told me, who was then head of Thistletown and in Thistletown the Ontario Government deserves all the credit in the world for putting it in, it is a fine institution, there is nothing like it that I can discover.

Dr. Rich at Thistletown told me that if he could have my boy for six months to twelve months, he could effect a cure or a reasonable facsimile thereof. This was when the boy was about twelve to thirteen years old. I had him on the waiting list for Thistletown and he was 185th on the waiting list. Thistletown was not in full operation, but when it was in full operation, I believe they can handle 70 emotionally disturbed children, but it would take 120 trained personnel for the job.



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he was first on the waiting list. Littleton was the

in my opinion, and then it was in full operation. I

believe they can handle 50 or 60 or 70 or 80 or 90 or 100 or 110 or 120 or 130 or 140 or 150 or 160 or 170 or 180 or 190 or 200 or 210 or 220 or 230 or 240 or 250 or 260 or 270 or 280 or 290 or 300 or 310 or 320 or 330 or 340 or 350 or 360 or 370 or 380 or 390 or 400 or 410 or 420 or 430 or 440 or 450 or 460 or 470 or 480 or 490 or 500 or 510 or 520 or 530 or 540 or 550 or 560 or 570 or 580 or 590 or 600 or 610 or 620 or 630 or 640 or 650 or 660 or 670 or 680 or 690 or 700 or 710 or 720 or 730 or 740 or 750 or 760 or 770 or 780 or 790 or 800 or 810 or 820 or 830 or 840 or 850 or 860 or 870 or 880 or 890 or 900 or 910 or 920 or 930 or 940 or 950 or 960 or 970 or 980 or 990 or 1000 or 1010 or 1020 or 1030 or 1040 or 1050 or 1060 or 1070 or 1080 or 1090 or 1100 or 1110 or 1120 or 1130 or 1140 or 1150 or 1160 or 1170 or 1180 or 1190 or 1200 or 1210 or 1220 or 1230 or 1240 or 1250 or 1260 or 1270 or 1280 or 1290 or 1300 or 1310 or 1320 or 1330 or 1340 or 1350 or 1360 or 1370 or 1380 or 1390 or 1400 or 1410 or 1420 or 1430 or 1440 or 1450 or 1460 or 1470 or 1480 or 1490 or 1500 or 1510 or 1520 or 1530 or 1540 or 1550 or 1560 or 1570 or 1580 or 1590 or 1600 or 1610 or 1620 or 1630 or 1640 or 1650 or 1660 or 1670 or 1680 or 1690 or 1700 or 1710 or 1720 or 1730 or 1740 or 1750 or 1760 or 1770 or 1780 or 1790 or 1800 or 1810 or 1820 or 1830 or 1840 or 1850 or 1860 or 1870 or 1880 or 1890 or 1900 or 1910 or 1920 or 1930 or 1940 or 1950 or 1960 or 1970 or 1980 or 1990 or 2000 or 2010 or 2020 or 2030 or 2040 or 2050 or 2060 or 2070 or 2080 or 2090 or 2100 or 2110 or 2120 or 2130 or 2140 or 2150 or 2160 or 2170 or 2180 or 2190 or 2200 or 2210 or 2220 or 2230 or 2240 or 2250 or 2260 or 2270 or 2280 or 2290 or 2300 or 2310 or 2320 or 2330 or 2340 or 2350 or 2360 or 2370 or 2380 or 2390 or 2400 or 2410 or 2420 or 2430 or 2440 or 2450 or 2460 or 2470 or 2480 or 2490 or 2500 or 2510 or 2520 or 2530 or 2540 or 2550 or 2560 or 2570 or 2580 or 2590 or 2600 or 2610 or 2620 or 2630 or 2640 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or 5150 or 5160 or 5170 or 5180 or 5190 or 5200 or 5210 or 5220 or 5230 or 5240 or 5250 or 5260 or 5270 or 5280 or 5290 or 5300 or 5310 or 5320 or 5330 or 5340 or 5350 or 5360 or 5370 or 5380 or 5390 or 5400 or 5410 or 5420 or 5430 or 5440 or 5450 or 5460 or 5470 or 5480 or 5490 or 5500 or 5510 or 5520 or 5530 or 5540 or 5550 or 5560 or 5570 or 5580 or 5590 or 5600 or 5610 or 5620 or 5630 or 5640 or 5650 or 5660 or 5670 or 5680 or 5690 or 5700 or 5710 or 5720 or 5730 or 5740 or 5750 or 5760 or 5770 or 5780 or 5790 or 5800 or 5810 or 5820 or 5830 or 5840 or 5850 or 5860 or 5870 or 5880 or 5890 or 5900 or 5910 or 5920 or 5930 or 5940 or 5950 or 5960 or 5970 or 5980 or 5990 or 6000 or 6010 or 6020 or 6030 or 6040 or 6050 or 6060 or 6070 or 6080 or 6090 or 6100 or 6110 or 6120 or 6130 or 6140 or 6150 or 6160 or 6170 or 6180 or 6190 or 6200 or 6210 or 6220 or 6230 or 6240 or 6250 or 6260 or 6270 or 6280 or 6290 or 6300 or 6310 or 6320 or 6330 or 6340 or 6350 or 6360 or 6370 or 6380 or 6390 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or 7650 or 7660 or 7670 or 7680 or 7690 or 7700 or 7710 or 7720 or 7730 or 7740 or 7750 or 7760 or 7770 or 7780 or 7790 or 7800 or 7810 or 7820 or 7830 or 7840 or 7850 or 7860 or 7870 or 7880 or 7890 or 7900 or 7910 or 7920 or 7930 or 7940 or 7950 or 7960 or 7970 or 7980 or 7990 or 8000 or 8010 or 8020 or 8030 or 8040 or 8050 or 8060 or 8070 or 8080 or 8090 or 8100 or 8110 or 8120 or 8130 or 8140 or 8150 or 8160 or 8170 or 8180 or 8190 or 8200 or 8210 or 8220 or 8230 or 8240 or 8250 or 8260 or 8270 or 8280 or 8290 or 8300 or 8310 or 8320 or 8330 or 8340 or 8350 or 8360 or 8370 or 8380 or 8390 or 8400 or 8410 or 8420 or 8430 or 8440 or 8450 or 8460 or 8470 or 8480 or 8490 or 8500 or 8510 or 8520 or 8530 or 8540 or 8550 or 8560 or 8570 or 8580 or 8590 or 8600 or 8610 or 8620 or 8630 or 8640 or 8650 or 8660 or 8670 or 8680 or 8690 or 8700 or 8710 or 8720 or 8730 or 8740 or 8750 or 8760 or 8770 or 8780 or 8790 or 8800 or 8810 or 8820 or 8830 or 8840 or 8850 or 8860 or 8870 or 8880 or 8890 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Brown

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We come down to the problem again, we can find money for missiles and warfare, but not for these children, and to me they are more important because they are the potential dangers to our society, they are the intelligent ones as well. You would not send a man with a broken leg to Don Jail and if you did there would be a huge public outcry, but you continually ignore these children. When I say "You" I mean society in general, ignore these children, pass them by on the other side of the road.

We have tried everything, I could go through the whole long story. We have tried everything, we have had him into the psychiatric hospital and they told me, it was not very scientific, they said, "He is an 'in-betweenner', not enough to be certified, not enough to have any place to go". He resents all society, the black jeans, the black shirt, the motor cycle clubs, the jack-boots, these are the things, the duck-tail haircut, these interest him. Why? Because we are ignoring him, we have no place to send him. I am not equipped to handle him, I have tried everything, I have implored, I have pleaded for help. I am willing to try and I am willing to pay for it. What about those that cannot pay for it. They say these children come from broken homes and I know a great percentage of them do, but you will find they come from every strata of society; you can go up into Forest Hill and find them and they are a very great menace. I would say this, if you ignore this problem, these are the ones who create your infernos like World War II and so on, because I have no doubt that Hitler was an emotionally disturbed child.



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/MR/hm

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MR. BROWN: Where do you go? What do you do? I think you have got to get behind institutions like Boys Village, but you have got to consider that as a mere drop in the bucket. This is wonderful work that is being done here but it is being done with a maximum of 30.

Thistletown is a magnificent job with a maximum of 70. Which is more important? Which is cheaper economically? To let these children go as they are, and I am speaking here mainly of those above the age of 11, 12, and 13, simply because there are efforts being made but they do not include the ones beyond that age. Because what is going to happen? They are going to be the ones that are going to fill your penitentiaries. They are going to be the ones who commit your crimes. They are going to be the ones who are a burden on society. They are going to be the ones who marry and what kind of a family are they going to raise?

If you work on them now and turn them into useful tax-paying contributing citizens, which is the better? This is essentially a health problem but it is a problem for the whole of society. You can only skim the problem here.

I came because I felt so deeply convinced that something should be said from somebody who has had some experience on the subject personally. It is not easy to talk this way and it is not easy to say these things and we love our boy. We know what he can do but he cannot do because Society won't let him and if the Health Commission did nothing else but go to work



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Brown

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4 on this problem, which is the root of many more problems,
5 it would be performing a monumental service, in my
6 opinion. Thank you.

7 THE CHAIRMAN: Thank you Mr. Brown.

8 We appreciate the sincerity and the effort by you to
9 support this submission here. I think I might say this.
10 Perhaps create a false expectation if you could foresee
11 the solution to many of these almost insoluble problems
12 but I think one purpose that this Commission has served
13 as we have held public hearings in all the Provinces of
14 Canada is that we have provided a place where many of
15 these problems which were not receiving sufficient
16 public attention have had an opportunity to be brought
17 out and discussed in relation to their health aspect and
18 as pointed out the areas of health service where
19 great deficiencies exist in Canada are in these
20 peripheral areas and not necessarily with the accent,
21 and so forth, upon merely providing physician services
22 by one means or another.

23 Perhaps in the long run some good
24 may well come by us having been around and from submissions,
25 such as we have had from you gentlemen here today. We
26 want to thank you for being here.

27 MR. FISHER: On behalf of the Boys
28 Village I would like to say that we appreciate tremendously
29 the opportunity of airing these problems. Thank you
30 very much.

12044 Brown

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MR. THOMPSON: On behalf of the Boys
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the opportunity of airing these problems. Thank you
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Brown

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THE SECRETARY: The next submission is from the Department of Public Welfare of the City of Toronto which will be known as exhibit 354 and Alderman Brown will begin and present this submission.

---EXHIBIT NO. 354: Submission of the Department of Public Welfare of the City of Toronto.

SUBMISSION OF
THE DEPARTMENT OF PUBLIC WELFARE
OF THE CITY OF TORONTO

APPEARANCES: Alderman H. Brown
Commissioner R. J. Morris
Mr. W. A. Turnbull
Mr. R. V. Henderson

THE CHAIRMAN: Mr. Brown?

ALDERMAN BROWN: Mr. Commissioner, and members of the Commission, I put on my aldermantic hat now and his Worship the Mayor asked me to convey to you his very great interest and to say that he was sorry he would have to be out of the City. As Chairman of the Committee on Public Welfare, Fire and Legislation he asked me to present the City's brief to the Commission.

You have before you the Mayor's letter I believe and we could probably consider it as a matter of record. I might amplify certain aspects of that in regard to additional information to at least some of the things we have worked in this brief. Now we have lately got a computer complex at City Hall, so we are able to evaluate a great deal more quickly and so we are breaking



Brown

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4 things down a little more than we have in the past and
5 one of the things that has become alarmingly apparent
6 is that -- you realize, of course, we have two classifica-
7 tions unemployables and unemployed employables and what
8 is happening is the shift to unemployed unemployables
9 is very great and these are primarily health cases.

10 I might just read some of these
11 figures here. This is during March 1962 as far as the
12 City of Toronto is concerned. Families employable 2,947.
13 Unemployed employables 2,693. Separate individuals
14 4,179, that is unemployables. Unemployed employables
15 1,334 for a total 7,126 unemployables and 4,027
16 unemployed employables.

17 Of the 2,947 employable families
18 approximately 35% required welfare assistance because
19 of health problems of the breadwinners. Of the 4,179
20 unemployable separate individuals, approximately 80%
21 required welfare assistance because of health problems.
22 This to us is extremely significant. The unemployable
23 cases in receipt of welfare assistance during March 1962
24 included 371 families and 592 separate individuals,
25 a total of 963 cases who were formerly in the unemployed
26 employable group of recipients. You see this alarming
27 shift we are talking about because of health reasons.
28 Now what I am going to read to you ---

29 THE CHAIRMAN: Are you able to expand
30 these health reasons. Is it because of unemployment?

ALDERMAN BROWN: Well of course there
could be worry, and so on. I would ask the Commissioner
to answer that. Commissioner Morris.

Room.

things down a little more than we have in the past and one of the things that has become alarmingly apparent is that -- you realize, of course, we have two classifications unemployed and unemployed employees and what is happening is the shift to unemployed unemployed is very great and these are primarily health cases. I might just read some of these

figures here. This is during March 1962 as far as the City of Toronto is concerned. Families employable 2,947. Unemployed employees 2,693. Separate individuals 4,179, that is unemployed employees. 1,334 for a total 7,196 unemployed and 4,027 unemployed employees.

Of the 2,947 employable families approximately 35% required welfare assistance because of health problems of the breadwinner. Of the 4,179 unemployed separate individuals, approximately 80% required welfare assistance because of health problems. This to us is extremely significant. The unemployed cases in receipt of welfare assistance during March 1962 included 371 families and 593 separate individuals, a total of 964 cases who were formerly in the unemployed employable group of recipients. You see this alarming shift we are talking about because of health reasons. Now what I am going to read to you ---

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4 MISS MORRIS: Mr. Chairman, when we
5 say there is a health difficulty it means that the
6 patient's private physician has completed the form
7 required by the Provincial Department of Public Welfare
8 and the application certifying as to a health condition
9 and the length of time which the person may be unemployable.
10 Also noted, as the Chairman has said, these cases, 963
11 of them in March were previously in the unemployed
12 employable group of recipients and then having had to
13 transfer over to what we call the unemployables or the
14 regular category of welfare.

15 It is known that a prolonged period
16 of unemployment may have a deteriorating effect on a
17 breadwinner's health and (2) there is the incidence of
18 illness which, when the person has recovered, then he
19 hopefully should be able to return to work.

20 ALDERMAN BROWN: Now one thing we have
21 in this -- does that answer the question?

22 THE CHAIRMAN: Yes, thank you.

23 ALDERMAN BROWN: Is that, let's take
24 during 1961, month of January and February and March
25 1962. Unemployables in the year 1961 were 5,806 or
26 55% and the unemployed employables were 4,821 -- 45%,
27 a total of 10,627 but for the first three months of
28 1962 the unemployed unemployables were 1,772 -- 63%
29 and the unemployed employables were 1,058 -- 37%.

30 Now this indicates, we believe, ill
health is a major cause of the continuing need of welfare
assistance in this City.

One of the very great difficulties we

MISS MORRIS: Mr. Chairman, when we

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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

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4 run into, and this will be of great interest to your
5 Commission I am sure, in fact we already approached the
6 Province in this regard and our Committee met with the
7 Honourable Louis Cecile, Minister of Welfare about a month
8 ago, I believe it was, and received a very cordial
9 hearing, and he recognized the problem. I am sure it
10 does not exist just in Ontario but as you know, the
11 regulations under the General Welfare Assistance Act
12 of Ontario provide for medical services for recipients
13 of welfare assistance and their dependents from private
14 physicians of their choice. The Provincial Department
15 of Public Welfare assumes 80% and the municipality 20%.

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Brown

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The regulations do not include any provision for prescription drugs, although these are absolutely essential to the rendering of any medical service in the community. Therefore, the cost of prescription drugs must be borne entirely by the municipality.

Now, in 1961 the City of Toronto paid \$183,453 for prescription drugs on behalf of recipients of general welfare assistance. That was in 1961.

THE CHAIRMAN: For how many people? Are you able to give us the figure?

ALDERMAN BROWN: We have the number each month. We have a breakdown here we could give you.

THE CHAIRMAN: I was just trying to see if I could pick a per capita out of that for another purpose.

MISS MORRIS: In December the average cost per case was \$7.17; in November, \$7.16. It ranged from ----

THE CHAIRMAN: Did you break it down to prescriptions?

MISS MORRIS: No, we didn't do that because one case might have three or four prescriptions and we felt that it had more meaning from our standpoint in the Welfare Department.

THE CHAIRMAN: Yes, I quite understand. I thought maybe I might abstract a figure out of thin air that I have been looking for.

ALDERMAN BROWN: I can give you quite



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Brown

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a figure here though. That is the total cost of medicines for 1960, \$40,183. 183,000 the following year. It is going up.

COMMISSIONER VAN WART: Your ratio of sick people went up.

ALDERMAN BROWN: The months of January, February and March, 1962, the estimated liability is \$62,245. Up, up, up. Now, we consider that the cost of this expenditure should not have been borne by the municipality alone. We don't think it is proper and I think I could add some weight to that by showing you -- we cannot turn people away. I mean, when they are in need we take the view that welfare is not a privilege. It is a right. If it is needed it should be provided. They have earned it as citizens of this country, but there were 455 cases in January of recipients who came from outside the City of Toronto. 567 in April; 514 in July; 508 in October; 516 in November. This is 1961.

Now, also these cases had to have prescription drugs. 32 in January; 145 in April; 192 in July; 172 in October; 242 in November. Always up; and incidentally, in the October one we did a breakdown. We found that 71 municipalities were represented. It is absolutely fantastic.

In other words, the percentage of the total number of these cases which received prescription drugs in January, 1961, was 7%, but in November, 1961, the percentage of that number was 46.9%.

Now, if that is not health, what was it?



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Brown

12051

We spent \$181 for this group in January. We spent \$1,718 for it in November and it kept going up, as I say, in the intervening months.

We pride ourselves that in the City of Toronto we try to keep our standards high. We know that welfare in most cases is just a subsistence. Nobody wants to be on welfare, but we keep our standards high. We try to do all we can. Maybe that is why some of them came in from other municipalities. I don't know, but we cannot turn them away.

Now, another problem is the nursing home care program. We have had a lot of help from the Ontario Hospital Services Commission, I mean, there has been progress made in that area. Don't forget, however, such benefits may be terminated on the basis of having received maximum medical care, without the required facilities or resources being available immediately for the care and maintenance which the patients may require upon discharge from hospital. Where do they go? What do they do? Well, they have to fall back on our Welfare Department.

I might add here, in parentheses, in very large parentheses, that when we visited Mr. Cecile, the Minister of Welfare, he pointed out that the City of Toronto is extremely fortunate to have one of the finest Welfare Commissioners in the country in the person of Miss Robina Morris, and we agree wholeheartedly with him, but the regulations include care and maintenance of infirm patients in private, licensed homes. The provincial Department of Public Welfare contributes 80%



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Brown

12052

of the first 100 dollars paid each month by the municipality for approved patients for private nursing home care. In 1960 we admitted 269 patients to private nursing homes. In 1961 we admitted 310. Now, the number of days' maintenance paid to nursing homes in 1960 was 50,062. In 1962, 61,229.

We think, I mean, I am not too great a believer in figures, except when they show something. I think these figures really show something, that there is a definite and rather alarming trend, which is purely based on health considerations and if this trend is available throughout the country, if it continues, if it is the same trend throughout the country, where is it leading us? Where is it leading us to our permanent unemployables? Isn't it better to get them back on their feet in a health way, get them back so that they can get back into society, do what they want to do, and that is to go back to work, because you know, 99% of people on welfare, despite what is said, do not want to be on welfare. They want to work.

But, you know, there comes a point after a long period of time when this sort of thing, well, it becomes almost a habit, and as the Commissioner said, it often leads to grave health problems.

THE CHAIRMAN: Mr. Brown, accepting, as we do, what you have said there, this progression is apparently due to health reasons, this progression of expense and numbers. Are these people actually doing without medical services now?



Brown

12053

ALDERMAN BROWN: Well, I didn't touch on that, and perhaps I should have.

THE CHAIRMAN: You see, we are concerned with health services.

ALDERMAN BROWN: No, we are providing what we can, but we do feel that this should not be a burden upon the municipality solely.

THE CHAIRMAN: I quite understand that, but we are concerned about whether any other system would give them better health services, and therefore would keep the number who are going from the one category to the other stationary. Do I make myself plain?

ALDERMAN BROWN: It is a poser, isn't it?

MISS MORRIS: We do believe that the City of Toronto has some of the best facilities available anywhere for the giving of medical services to persons who need them, and they are being rendered to the extent of their availability. They certainly are being rendered now. If it were not for the City of Toronto putting out the amount of money which they pay for medicines as a matter of civic policy, these recipients would undoubtedly have to go without medicines.

THE CHAIRMAN: That is quite true but merely by shifting the manner of payment would we improve the health condition? We would improve the financial condition of the City of Toronto, but would we improve the health of these people?

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Brown

12054

ALDERMAN BROWN: No, because I think what we are doing is a drop in the bucket.

THE CHAIRMAN: What do you mean by that?

ALDERMAN BROWN: Because I think that we should carry this much further.

THE CHAIRMAN: I mean, a drop in the bucket in other ways, but I mean medically, and with furnishing medication. You are not saying that that is a drop in the bucket?

ALDERMAN BROWN: No, I think we are doing pretty well there.

THE CHAIRMAN: You are doing well, but if there were some other system, if the Provincial Government were paying for it, would they be any better off?

ALDERMAN BROWN: I think we gave an answer to that in the brief which we presented, when we said from a public welfare standpoint, ill health is a major cause of potential chronic dependency due to unemployability of breadwinners and represents one of the most serious problems in public welfare at the municipal level of government.

And the concluding paragraph; it is considered that the health of the nation is of such paramount importance that only a program instituted by and with the resources of the Federal Government could provide the leadership and services necessary for its fulfilment.

THE CHAIRMAN: The only question we



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THE CHAIRMAN: The only question we



Brown

12055

are putting to you, and if you could answer it, all right, is, would it make any difference whether the money came from Ottawa, or was coming from the coffers of the City of Toronto? Would they get any better health service?

ALDERMAN BROWN: Yes, because we get money to provide better services. I think it is a matter which requires leadership of the Federal Government.

THE CHAIRMAN: What do you mean by better service?

ALDERMAN BROWN: Well, fuller services. I don't think that we are going -- we are doing all we can, and as I say, our standards are higher than most, but still it is not enough, not if we are going to put these people back on their feet, not if we are ---

THE CHAIRMAN: I am talking now merely of illness.

ALDERMAN BROWN: So am I. I am saying if we are going to put the unemployables back into the employable bracket, then we are going to have to spend enough money and provide enough services to put them back on their feet.

THE CHAIRMAN: What services are they lacking now?

MISS MORRIS: Mr. Chairman, I think the situation is more a lack of overall policy and uniformity in the granting of medicines to people who require them. Now, in the medical treatment under the medical welfare services plan, which, as you know, is



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5 overall policy which applies throughout the Province
6 of Ontario. Where medications or prescription drugs
7 are concerned, there is no policy, and therefore each
8 municipality ---

9 THE CHAIRMAN: Yes, I know, and the
10 City of Toronto has to pay for them.

11 MISS MORRIS: In the City of Toronto
12 the civic administration has authorized the policy
13 which we have ---

14 THE CHAIRMAN: I accept that. You
15 have explained that and I don't want to prolong ---

16 MISS MORRIS: But there is no overall
17 uniformity, Mr. Chairman.

18 THE CHAIRMAN: The only question is:
19 what improvement, if any, would there be if the money
20 came from Queen's Park, instead of City Hall?

21 ALDERMAN BROWN: There would be more
22 money. The City of Toronto has only one basis of
23 taxation, but the Federal Government has another basis
24 of taxation.

25 THE CHAIRMAN: Are there people going
26 without prescriptions?

27 ALDERMAN BROWN: We trust not.

28 THE CHAIRMAN: Well, if you had a
29 million more, and everybody gets all the prescriptions
30 that the doctors have ordered for them, what would
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is why should the City ---

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Brown

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THE CHAIRMAN: That is another problem, I mean to say, and it is not one that can concern this Commission. I mean, the inter-financial relationships of the municipalities to the Provincial Government, thank Heavens, are outside our sphere. We have enough to concern ourselves with without being concerned with the financial arrangements of municipalities and government.

ALDERMAN BROWN: Then let us consider another aspect ---

THE CHAIRMAN: We are concerned with health services, and means of improving those services.



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Brown

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4 ALDERMAN BROWN: Well, actually I
5 think the people on welfare are better off than the other
6 categories mentioned in our brief, and that is the lower,
7 marginal income, and this is a very real problem,
8 because what we are finding is that some of these low,
9 marginal are becoming unemployable and they are going
10 on welfare. They can't afford it.

11 THE CHAIRMAN: Whether they can afford
12 it or not, they are not getting it.

13 the way they shall ALDERMAN BROWN: That is right. As
14 you know, you know it very well, illness may break a
15 family quicker than anything else, that is financially
16 and morally and everything else. Most of them are
17 travelling marginally and once that margin is broken
18 the descent is very rapid.

19 THE CHAIRMAN: The area above those
20 on social aid, you say there is real trouble there.

21 overall picture ALDERMAN BROWN: I would think so.

22 THE CHAIRMAN: Would you be able to
23 give us the size of that segment?

24 MISS MORRIS: No, but we can tell you
25 that last year, 1961, 10,621 cases applied for welfare
26 for the first time in their lives in the City of Toronto,
27 our department; in 1960 the number of cases was 12,286,
28 and in 1959 it was 9,485. So those people must come
29 from the low income group and have come to the end of
30 their own resources.

31 I think I might come back to what you
32 said, would they get any better medical service. Our
33 experience in administering public welfare programs has

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4 are regulations governing what you do. In the supply
5 of these medicines, regardless of what government level
6 pays for it, unless there are a set of regulations, which
7 can only come by legislation of a higher level of
8 government, then you cannot get the maximum benefit from
9 the program. That has been the case with all our welfare
10 programs. When there are regulations there is uniformity
11 and it is set forth, responsibilities are defined and
12 the way they shall be carried out, and that is very
13 significant in the success of whatever public welfare
14 program is your responsibility to carry out.

15 THE CHAIRMAN: Yes, I can follow that
16 quite clearly.

17 MISS MORRIS: So when you say would they
18 get any better medical care, actually they wouldn't get
19 any better medicine than they are getting now, but the
20 overall picture would be certainly improved in that there
21 would be overall policies and regulations and there would
22 be uniformity in the treatment in that respect.

23 ALDERMAN BROWN: And I think there would
24 be another area which would concern this Commission, and
25 that is this, that our standards in this respect are
26 high; we are paying these things. How many municipalities
27 are paying? Very few.

28 THE CHAIRMAN: We have to explore that,
29 too.

30 ALDERMAN BROWN: Yes. I believe you
wanted some test cases.

MR. TURNBULL: Mr. Chairman, Members, I



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Brown

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4 have one or two illustrations perhaps of these what
5 you might call borderline or low income groups. For
6 example, case number one. The man is 31, the woman is
7 26. This man suffers from a blood condition, which I
8 won't attempt to pronounce, that this condition is such
9 that it caused bleeding at the joints. Now, the
10 prognosis for this man is quite poor. The cost of the
11 drug is \$110.00 a month. The wife is employed, and we
12 are subsidizing this medication to the cost of \$49.50
13 a month. That is just one illustration.

14
15 Here is a case of a man and wife and
16 two children, and in this case it is the two children
17 who are in need of medications. The condition which
18 these children suffer from involves a diet supplement,
19 and if these children are not treated at the early stages
20 it will lead to gross mental retardation. The cost of
21 this drug is \$11.25 a tin, and the children require
22 13 tins per month. Now, that has varied when the father
23 has been able to secure temporary employment from time
24 to time. It has never gone below three tins a month on
25 our part, so it will vary from three tins to thirteen
26 tins a month which the Department is supplying. Now,
27 these are low income families.

28
29 Now, a family of three, the man and
30 wife are both 58 years of age. The man suffers from
carcinoma, the wife is also suffering from diabetes, and
she is blind. We are putting in for medication in there
at the rate of \$20.00 a month to supplement their pensions.
Now, these are just three examples I chose at random.

THE CHAIRMAN: These are the kinds of

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Brown

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4 things that if we had a prepaid program for drugs they
5 would automatically be taken care of by government at
6 some level.

7 MR. TURNBULL: Exactly, Mr. Chairman.

8 THE CHAIRMAN: And not wholly by the
9 City of Toronto?

10 MR. TURNBULL: Yes. I might add that
11 the medication is so high, even though the people are
12 not on public assistance, it is always a problem to
13 supply the money, which is a charge upon the City of
14 Toronto.

15 ALDERMAN BROWN: There is another
16 area which is not covered, and that is dental requirements.
17 There is no provision for fillings or treatment. The
18 only service we can get is extractions -- pull them out.
19 But, as you know, modern dental care is not based on that
20 at all, but because they are on welfare, pull them out.
21 We have asked for a report in our committee; we are
22 compiling statistics in this regard which we would be
23 glad to make available.

24 THE CHAIRMAN: Yes, we would be very
25 pleased to have them, because there are other studies
26 in this field.

27 ALDERMAN BROWN: Are you interested
28 in the gross cost groupings of the medicines?

29 THE CHAIRMAN: Have you a schedule
30 you can leave with us?

ALDERMAN BROWN: Well, I can get it
typed up and get it sent to your secretary.

THE CHAIRMAN: We have a study going on



12061

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4 ALDERMAN BROWN: I should say they
5 run anywhere from \$3.00 to \$111.00. We haven't hit
6 the \$111.00 and \$120.00 yet, but we will.

7 THE CHAIRMAN: It was very good of
8 you, Mr. Brown, and your associates to accept the
9 invitation to come, because, as I say, as our letter
10 indicates, we want to know just what the effects are on
11 the low income group of the absence of health services
12 or the inadequacy of health service, and that is where
13 your submissions, your responsibilities here are very
14 valuable to us.

15 There is another submission to be
16 submitted here this afternoon by Mrs. Miles. I don't
17 know if you wish to remain, whether it parallels in a
18 measure some of the things you have been talking about.

19 MR. TURNBULL: I wonder if I could have
20 one last word to say. It just occurred to me this is
21 a slight departure of what we are thinking of in terms
22 of medication, but it is becoming perhaps more apparent
23 lately, and that is a request for certain types of
24 machines which may be required in terms of treatment of
25 the individual.

26 I have a case of a man who was to be
27 discharged from hospital. This man suffers from
28 pulmonary emphysema and he requires a suction machine,
29 and this machine rents at \$35.00 a month.

30 THE CHAIRMAN: For how long?

MR. TURNBULL: It doesn't say precisely
for how long. This condition as indicated in this report

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Brown

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3 is fairly serious. It is marked and chronic, but whether
4 that would affect the term or time this machine would
5 be required I cannot say. But it represents another
6 type of medical service which we are being approached
7 to do something about.

8 THE CHAIRMAN: Do you operate a loan
9 coverage in that regard?

10 MR. TURNBULL: No, we have no provision
11 for that kind of thing, other than a supplementary
12 allowance in cash.

13 THE CHAIRMAN: Red Cross does.

14 MR. TURNBULL: We do explore all of
15 these possibilities and we are called upon in many,
16 many instances to provide at least part of it, defray
17 part of the cost.

18 THE CHAIRMAN: And it is always done
19 by way of a supplementary allowance?

20 MR. TURNBULL: Yes, where it is possible
21 for us to do so.

22 THE CHAIRMAN: How frequent is that?

23 MR. TURNBULL: It is not frequently,
24 it is nothing like the medications, but it does occur
25 often enough to give us concern, because each case is
26 determined on an individual basis and it is a matter of
27 where are you going to get the money from to meet this
28 situation. We might be issuing the medication shareable,
29 which is \$20.00 a month, but their medication and other
30 things may be considerably higher, and if it does it
becomes non-shareable or at the City's expense. And
prosthetic appliance, of course, is another consideration,



1961

is fairly serious. It is marked and chronic, but whether that would affect the term or time this machine would be required I cannot say. But it represents another type of medical service which we are being approached to do something about.

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Brown

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which is shared by the Province.

ALDERMAN BROWN: Certainly the City, I am sure, would agree with me, the committee and the mayor, that if there is any way we can assist you, make available to you, I am sure your secretary can get in touch with us.

THE CHAIRMAN: We had a letter from His Worship the Mayor saying if there was any information we were entitled to get he would see that it would be made available.

Now, this all adds up probably to one question. It is maybe much too broad and you may have to fragment it. When everything is taken into consideration, the situation, the system in Metropolitan Toronto, are there any people going without medical attention merely because they haven't the money to pay for the services when they are called for, I mean to say at the time they need them?

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ALDERMAN BROWN: Certainly the City.

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time they need them?



ch/ss2

Morris

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MISS MORRIS: Well, Mr. Chairman, as we put in the letter which His Worship the Mayor addressed to you, we know that low income families use public hospital clinics extensively, we know that. For the provision of the actual medicines the City of Toronto has no money to provide for the low income families their medicines. Now, the civic policy take the responsibility of general hospital assistance, therefore, only in very occasional instances can we assist the other group. For instance, last year we spent some \$5,000.00 in medication to the low income group.

THE CHAIRMAN: Is the fact of what you are saying that people are going without medication?

MISS MORRIS: I do not know that, but as we said in the brief, they would be suffering hardships if they required all their income for the basic necessities of life; they would certainly suffer hardships if they also required medicines and I think it makes a difference to the duration of the illness.

THE CHAIRMAN: My question was directed to medical services, I should have said physician services.

ALDERMAN BROWN: The Commissioner can correct me on this, because of his knowledge of the subject but my feeling is definitely this --- you say are any going without?

THE CHAIRMAN: Merely because they have not the money for which to pay for the services at the time they need it.

ALDERMAN BROWN: I say yes, because they are doing without till they are finally --- they have



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Brown

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to see a doctor.

THE CHAIRMAN: They may delay?

ALDERMAN BROWN: That is right, and things that should be caught in the early stages are allowed to grow and grow, that is my idea.

MR. TURNBULL: I think we have examples of that of people coming on public assistance because of a medical and it is discovered then that a condition existed for some time but they did not have the resources by which they could have obtained early medical attention. I could not give numbers.

THE CHAIRMAN: I am not asking for numbers.

MR. TURNBULL: In my own self I am convinced there are undoubtedly some of the low income group who are suffering because of their inability to get medical service by virtue of money.

THE CHAIRMAN: And that manifests itself in delay until the time comes when they have to have it regardless.

ALDERMAN BROWN: And you know that is particularly true of dental care because that seems to be the area where they --

THE CHAIRMAN: They stay away as much as possible.

ALDERMAN BROWN: They feel they can stay away and you know how many illnesses stem from improper dental care. I would say a very large percentage of that sort of thing exists because people cannot afford it. Some people, of course, are proud, they just do not want



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Brown

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to appeal for assistance and they let this thing go. Now, if they had some place to go to, if they had paid into it, had a prepaid system, they would say "I paid for it, I will go and get it", and there would be no thought in their mind but when they have not the money and it is going to cost them, they let it go until they become a charge upon the State.

COMMISSIONER VAN WART: Some do not go even if it is available to them.

ALDERMAN BROWN: True.

MISS MORRIS: I think, Mr. Chairman, we should mention here the role of the Department of Public Health in the City of Toronto. As far as school children are concerned there are public health nurses in every school and I am quite satisfied that the nurses pay very careful attention to the health of the children. If necessary, the nurse also visits in the homes, following up the health needs of the children. For the pre-school children and the infants there are the well-baby clinics which again give the Department of Public Health an opportunity of finding out the health conditions. If we hear of any family not in receipt of welfare assistance because if they are they can have their own doctor and they may object, but if there is illness in a family not in receipt of welfare assistance, we immediately report it to the Department of Public Health and I know they would feel sure of help if they knew about it and would have something done to meet the emergency.

THE CHAIRMAN: Thank you very much. You have been very helpful and very, very informative.

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THE CHAIRMAN: Thank you very much.

You have been very helpful and very, very informative.



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We are grateful to you and we may be calling upon you by correspondence for further information, I am quite sure we will be.

THE SECRETARY: Mr. Chairman, the next brief is that of Mrs. Marguerite Miles, and this will be known as Exhibit 355.

---EXHIBIT NO. 355: Submission of Mrs. Marguerite Miles.

S U B M I S S I O N O F
-- MRS. MARGUERITE MILES

MRS. MILES: I wish to appear before the Commission as one who for six years has attempted to procure medical care for my asthmatic child and to question the belief that is so persistently put forward, i.e., "no one in Ontario has to go without medical attention for lack of funds."

In June, 1956, my child, then seven months old, suffered his first asthmatic attack and had to be hospitalized. Within the next four months, hospitalization was a frequent occurrence. During this time \$1,200 was spent on medical bills. At the end of this period a specialist took over the case and the projected medical expense for an indefinite period of time was approximately \$2,000 per year. Of this amount, \$1,100 was to go out on hospitalization, \$500 on hypo-desensitization needles, about \$200 on cortisone and another \$200 or so on sundry drugs, dietary milk, etc. The funds to support this



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---EXHIBIT NO. 355: Submission of Mrs. Marguerite

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about \$200 on cortisone and another \$200 or so on sundry
drugs, dietary milk, etc. The funds to support this



Miles 12069

medical treatment were lacking.

What does one do when faced with the prospect of a medical expenditure such as this? One can go without medical help and sometimes die. One can, as an official of the Department of Public Health advised me, sell what assets they possess and go into debt. One can receive Welfare Assistance from the City of Toronto, but to receive this assistance one must become a fourth-class citizen - an indigent - and that is what I became. As a recipient of Welfare Assistance I was allowed \$23.00 per week for rent, food and clothing, etc., for myself, one healthy and one ailing child. To ensure that a recipient is an indigent as he is supposed to be, one receives monthly unannounced visits from investigators who demand to see how much food there is in the frig and how much money one has in their purse at the time of the visit.

On one occasion when I was interviewed by an official of the Department of Welfare with regard to being allowed to work, he advised me to remain on Welfare as I would not have a hope otherwise of meeting my medical expenses.

Does the patient receive the same standard of treatment under welfare assistance as they would if they were a self-supporting patient? Generally, I think that one does. I remember clearly, however, an occasion when my child was extremely ill and a bronchoscope had to be performed. The doctor who performed this task was very angry when he discovered that the patient was covered under a welfare account.

Do doctors discriminate against Welfare



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No doctors discriminate against welfare



Miles 12070

Patients? My child's doctor at the end of a year's treatment sent a copy of a letter to me which he had written to the Department of Welfare. In this letter he stated, "I will look after this child, if necessary, for nothing, which is what I do with Welfare paying the account."

In December of 1961, I was transferred over to the Province of Ontario, and I received a letter at this time informing me that the Department of Mothers' Allowances were pleased to advise me that I was now under their care. Two months later, in February of this year, I received a letter from that Department informing me that I was no longer under their care. Why was I no longer eligible for assistance? In brief, the child's care had been changed and his new doctor prescribed medication that was not, in the strict sense, drugs. These medicines cost about \$50.00 per month. Mothers' Allowance refused to pay for this medication and I was forced to earn money (\$14.00 per week) to pay for them. I was now "breaking the law" and it was not long before one of their investigators discovered my crime. Although I requested re-consideration of their decision, and although I showed them my medical bills, I was advised that I was no longer considered a needy case.

In my attempt to raise the money for my child's heavy medical bills, I contacted the following agencies:

Red Cross: "They can't put you off Mothers' Allowance with a sick child - phone the Department of Public Health."

Dept. of Public Health: "Get in touch with the Department



Miles 12071

of Welfare."

Dept. of Welfare: "We cannot do anything about your situation without the consent of Mothers' Allowance as they pay a portion of our expenses. Get in touch with Mothers' Allowance." The gentleman in charge of the department there refused to speak to me or grant an interview or come to the phone.

Neighbourhood Workers: "I suppose you realize that by earning this extra income, you were breaking the law."

Social Planning Council: "You surely do not feel that you are entitled to a private doctor's care when you do not have the money to pay for it. You should attend the clinic. That is really all you can expect now, isn't it." May I quote from the child's doctor's letter again..."I have continued to look after him because his condition is extremely severe and I feel that it would be most difficult for someone who does not know his history to take him over."

After being passed around from one agency to another and failing to find any assistance whatsoever, I would like to know the answer to one question: To whom does one look for this "medical attention that no one in the Province of Ontario is supposed to be without." An answer to this question is, I feel, an answer to whether or not complete health services would be beneficial to the people of Canada.

THE CHAIRMAN: That is your story, Mrs. Miles?



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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Miles 12072

MRS. MILES: Yes, that is my story.

THE CHAIRMAN: As you will appreciate,

it is only in the last sentence that what you say is really relevant to the inquiry. The fact is that this Commission has no power to give medical service or anything of that kind. However, we are concerned with learning just what the situation is in Canada in relation to the need for or whether there exists a need for a comprehensive medical health services program. To that extent the information you have given us adds to the information we have had; it does deal with an individual case and, of course, it is the individual cases that go to make up a total and eventually demonstrates need.

On behalf of the Commission I can only say we are grateful to you for having brought your problem in this way before the Commission as it illustrates to the extent that you have developed it the need for health services to cover people in your situation. I suppose that is what you wanted to do. Is there anything else?

MRS. MILES: No, not as far as I am concerned, thank you.

THE CHAIRMAN: We will adjourn now until nine-thirty tomorrow morning.

---Adjournment.



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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

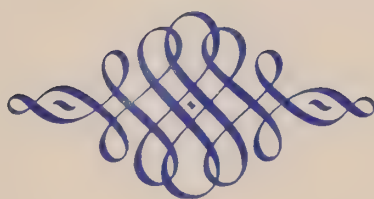
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings
held in Toronto, Ontario,
on the 31st of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R. N.

DR. C. L. STRACHN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O. J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE

ALLEGED VIOLATION OF HEALTH STATISTICS

Witnesses of the hearings
held in Toronto, Ontario,
on the 31st of May, 1962.

Witnesses of the hearings

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---On resuming at 9:30 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning is the Canadian Welfare Council to be known as exhibit 356 and Mr. Fisher will introduce his group.

---EXHIBIT NO. 356: Submission of the Canadian Welfare Council.

SUBMISSION OF
CANADIAN WELFARE COUNCIL

APPEARANCES: Mr. P.S. Fisher
Mr. R.E.G. Davis
Dr. G.M. Hougham
Mr. H. Racine
Mr. W. M. Anderson

MR. FISHER: Mr. Chairman, Miss Girard, gentlemen, may I first say how very much indeed we appreciate the opportunity of attending before you today and offering you officially this submission.

I believe you already have received copies of our submission and perhaps I should apologize because it is a pretty bulky document and I understand you only received it a very few days ago. We have had quite a job getting it ready, as a matter of fact. We have done our best and we hope that it will be of some use to you.

I am really here pinch-hitting for our president, Mr. Carter, who was unavoidably absent today and asked me to present his apologies.



--On meeting at 8:30 a.m.

THE SECRETARY, Mr. Chairman, the
sion this morning is the Canadian Welfare
Council to be known as Exhibits 806 and Mr. Fisher will
Presentation of the Canadian

PRESENTATION OF

- Mr. W. M. Anderson
- Mr. R. B. Baine
- Mr. J. M. Hodgson
- Mr. H. C. Davis
- Mr. J. S. Fisher

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I am really here pinching time for our
President, Mr. Carter, who was unavoidably absent today
and asked me to present his apologies.



Fisher

12074

Associated with me are Mr. Horace Racine of Ottawa, who is the Chairman of the French Commission of the Council. Mr. R.E.G. Davis, the Executive Director of the Council and Dr. George Hougham, the Director of our Research Department. I don't quite know Mr. Chairman how you want us to proceed.

THE CHAIRMAN: Mr. Fisher, if you wouldn't mind sitting down, and taking it informally.

MR. FISHER: Perfectly happy to sit down.

THE CHAIRMAN: If you wish to read the summary and recommendations that will probably be the most acceptable way of getting it before us. If that suits you.

MR. FISHER: Mr. Chairman, I would like to make just one general observation and then perhaps turn the task of summarizing the summary over to Dr. Hougham.

Obviously the preparation of a health care plan must start off with the medical profession, the actual medical services. We submit that any national plan has very heavy implications of the sociological nature. Health is not a part of man that can be separated from the rest of him.

I think probably the economist would say that there are pretty important economic implications to a plan of this kind.

Also, we don't pretend to any competence in the field of applied medicine or in the field of economics but we think that the Council, through its



Fisher

Associated with me are Mr. Horace

Washburn of Ottawa, who is the Chairman of the French

Commission of the Council. Mr. R. H. Davis, the

Executive Director of the Council and Dr. George H. Brown,

the Director of our Research Department. I don't quite

know Mr. Chairman how you want us to proceed

THE CHAIRMAN: Mr. Fisher, if you

MR. FISHER: Perfectly happy to sit

down.

THE CHAIRMAN: If you wish to read the

summary and recommendations that will probably be the

most acceptable way of getting it before us. If that

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MR. FISHER: Mr. Chairman, I would like

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intimate association with welfare activities and problems for a very long time perhaps has some competence in the field of social planning and in judging the impact of health plans on the general population. It is from the point of view of social planning that our brief has been drafted.

In other words, we have not tried to cover the whole field of your terms of reference. We have approached this from the point of view of the welfare angle. Now, Mr. Chairman, if I may, I will ask Dr. Hougham if he will do his best to deal as briefly as possible with the summary. I don't think we will burden you with reading the whole thing in total because I think this would be a matter of some forty minutes. I doubt if you want to spend that much time on it.

THE CHAIRMAN: Thank you very much. I think you will find that while we may not have had time enough to digest the complete submission, we have had an opportunity to look it over and are familiar, in part with it, and therefore we would appreciate just whatever Dr. Hougham says.

DR. HOUGHAM: In what detail would you like the summary dealt with?

THE CHAIRMAN: We leave that to you. Do it in your own way. In the most effective way you think it can be done.

DR. HOUGHAM: Mr. Chairman, with your permission I think what I will do is read and at points skip and indicate where I am so doing. This is from the blue sheets, the summary of the submission.



GUIDING PRINCIPLES IN HEALTH CARE

The Council believes that any assessment and further development of health care and health services for the Canadian people should be guided by five broad principles, as follows:

1. Health services should embody a philosophy which is oriented to the needs and feelings of the patient and his family.

It is therefore vitally important that:

a) The motivation of personnel in health care, as in all human service professions, should be service to people.

b) The sick person should receive care and treatment as an individual human being, with unique needs and feelings.

c) Health services should be organized to make the fullest possible use of the resources of the home and family in the care and treatment of the sick. The patient should be removed from the home only when medical necessity makes it imperative.

d) The well-being of the patient rather than efficiency in any narrow sense should be the major test of the excellence of all health care arrangements and routines.

e) Economic considerations should neither be allowed to interfere with essential health care for the individual nor be the only criterion in determining priorities among health services or between such services and alternative uses of resources.



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4 2. The community has an interest and an obligation
5 to ensure that a full range of health services exists and
6 that, whether under public or private auspices, they
7 meet acceptable standards of quality. The individual
8 has a reciprocal obligation and interest not only to
9 seek to maintain the health and physical fitness of
10 himself and his family, but to support the development
11 and operation of adequate health services for everyone.

12 In the event of illness, actual or
13 threatened, the individual should have available the
14 health care facilities and services required for effective
15 diagnosis and treatment of his condition. Particular
16 services may be provided under public, voluntary, or,
17 in some cases, commercial auspices. However, only
18 governments are in a position to ensure both that the
19 full range of required services exists and that, regard-
20 less of auspices, they meet acceptable standards of
21 quality.

22 It is perhaps less frequently recognized
23 that, within the limits of his knowledge and capacity,
24 the individual has a matching duty both to seek to maintain
25 his own health and that of his family, and to support
26 adequate health services for everyone.

27 3. Because the health of the individual is
28 indivisible, health services should be closely co-ordinated
29 and health care for the individual should be integrated.
30 Similarly, the broad range of health and welfare services
which an individual or family may need should form a
co-ordinated network.

Although sometimes necessary for
purposes of analysis and assessment and of organization



to ensure that a full range of health services exists and that, whether under public or private ownership, they are available to all.

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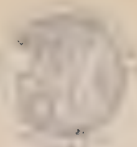
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4 of individual services, the separation of health care
5 into prevention, treatment and rehabilitation categories
6 tends to violate the concept of integrated health work.
7 Likewise, a sharp division between health and social
8 welfare should, as far as possible, be avoided; the
9 objectives of health and social welfare programs are
10 so interdependent as to be, in most instances,
11 inseparable.

12 4. There should be no economic barrier in Canada
13 to the availability of necessary health services.

14 The cost of adequate health care has
15 been rising steadily in recent decades. In the
16 relatively affluent society of today, however, people
17 expect that a full range of required health services
18 will be available in case of need. Nor should the cost
19 of adequate health care for all be viewed as entirely a
20 burden on the economy or a net addition to social
21 expenditure; most health expenditures are, in fact, a
22 sound economic investment in human capital.

23 I might mention that that principle
24 is almost a straight repetition of a point which we
25 made in a more general statement on social security, a
26 policy statement in 1958.

27 5. The constituent elements in a comprehensive
28 social security system for Canada should be developed,
29 financed and administered in a balanced and co-ordinated
30 manner. In this connection, ill health should be
recognized, much more than it is now, as a grave threat
- both in terms of wage loss and health care expenditures
- to the maintenance of adequate income.



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4 In terms of wage loss, the lack of any
5 legislation to require sickness cash benefits is a
6 serious weakness. In terms of health care expenditures,
7 the hospital insurance program constitutes partial
8 acceptance of the above principle but, at the same time,
9 contravenes it in part. Although the program has
10 extended substantially the area of public protection
11 against the costs of illness, it may also encourage an
12 unbalanced development by affording a financial advantage
13 and incentive for individual health care in the hospital.

13 PART II

14 CANADA'S HEALTH CARE OBJECTIVES

15 The Council recommends three broad
16 health care objectives for Canada, namely:

17 1. To keep to a minimum the incidence of illness
18 and the need for treatment services by assuring an adequate
19 standard of living for all Canadians, by encouraging
20 the best personal health habits, and by providing
21 effective public health programs, and preventive measures.

22 2. To secure a balanced development of health care
23 programs, facilities and services, adequate to meet needs,
24 of acceptable quality, efficiently administered and
25 effectively co-ordinated, and distributed so as to be
26 reasonably accessible to everyone in the nation.

27 3. To make certain that everyone in Canada has
28 access to the health services he needs at the time he
29 needs them, regardless of his ability to pay the cost
30 at the time of service.

Better health and more adequate health



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care for Canadians demand simultaneous progress toward all three objectives. The dimensions of these overall goals are suggested by the following requirements related to each:

1. Achievement of the first objective requires a wide variety of activities and programs, including the following:

a) Continued efforts to eradicate poverty and raise the general standard of living;

b) A network of programs which will provide adequate income maintenance in the event of interruption or loss of income, however caused; (Specific recommendations to ensure a network of adequate income maintenance programs are contained in the Council's policy statement, Social Security for Canada, June 1958.

c) A similar network of programs to encourage personal physical fitness and mental health, to teach good practice in personal hygiene and family nutrition, and to spread knowledge of good personal health habits and health care.

d) Measures - such as control of communicable disease and pollution; sanitation and food inspection; environmental hygiene, including



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enforcement of adequate housing standards; strongly based health and accident prevention programs for all age groups; and maternal and child welfare services - aimed at creating healthy citizens in a healthy environment.

2. Achievement of the second objective requires acceptance of community responsibility, and creation of necessary public machinery, national, provincial and regional, for the overall planning and co-ordination of Canada's health care services, public and private.

The components of the planning task include such matters as:

- a) The further development of health criteria and the conduct of periodic health surveys;
- b) A balanced program of research, controlled experimentation and demonstration projects concerning the causes of ill health and disease, methods of treatment, and the organization and administration of health services and programs;
- c) The development of a full range of health services, facilities and programs;
- d) The recruitment, training and remuneration of the professional and technical personnel required to man these services;
- e) The rational and equitable distribution of services, facilities and



personnel across the nation.

3. Achievement of the third objective requires
an overall nation-wide program for payment of health
care costs. This is dealt with later on. Here we note that
the program should guarantee that:
a) Everyone in Canada has the opportunity
to be covered, regardless of age,
physical condition, economic status,
occupation or location;
b) Although staging may be required,
all the facilities and services that
compose a recognized standard of com-
prehensive health care are included
within a reasonable period of time;
c) The health services which are made
available are of acceptable quality;
d) The cost of services is distributed
in a reasonably equitable manner,
with any premium or contribution within
the individual's ability to pay, and
without the administration of a means
test for any substantial group in the
population;
e) The administrative arrangements
are such as to ensure flexibility,
adaptability and responsibility in
the operation of health services;
adequate remuneration of professional
and technical personnel; continuity of
care; and a relationship of trust and



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confidence between the individual
patient and professional personnel
involved in his case.

PART III

Part III of the summary, which is a
summary of Chapter 4 of the complete submission discusses
certain broad trends and problem in Canadian health
care.

The Council directs attention to six
significant trends in current Canadian health services
as follows:

1. Science and technology have generated
a greater variety and complexity in health services and
a corresponding growth in professional and technical
specialties in health care. Moreover, the importance
of the scientific and technical components in adequate
health care is continuing to increase.

2. The spread of knowledge concerning
modern health services, together with a rising standard
of living, have created a widespread demand that the
potential benefits of present-day health care be made
available to everyone.

3. The growth of public interest in health
care has also been reflected in an increase in the number
of voluntary health organizations. This increase has,
in turn, added to the variety and complexity referred
to above, and has accentuated the problems of organization
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5. Prices of healthservices are not only rising, but are rising at a faster rate than the increase in the consumer price index.

6. Rising expectations and rising prices have converged to create a growing demand for collective protection against the unpredictable and unevenly distributed costs of health care.

Overall developments in the supply, the organization and the financing of Canadian health services have not kept pace with these six trends. By way of illustration, attention is directed to five problem areas in the current situation:

1. Problems of Information

We need, for example, up-to-date information on the extent of illness in Canada, in relation to the amount and type of treatment; current, comprehensive and co-ordinated information on Canada's health care programs, institutions and services, public and private; and comprehensive and comparable data on the distribution of health care costs among Canadian families, and on the various ways, public and private, in which these costs are being met.

2. Problems of Supply and Distribution

Years of planning and construction are now paying dividends in the provision of acute-care hospital beds. On the other hand, there are serious shortages in such areas as chronic, convalescent and nursing home facilities, mental illness services, rehabilitation programs, public health services, home-maker services, and organized home care programs.

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5 of planning and partly a function of gross shortages -
6 health personnel and facilities are very unevenly
7 distributed across the nation.

8 as follows. There is an illustration of that in
9 one of the appendices to the submission

10 3. Problems of Organization

11 suffers from. There is need for closer integration of
12 those health programs and services administered by the
13 federal government. In the brief we note that they
14 are distributed among a wide variety of government
15 departments and agencies. Better machinery is required
16 for co-ordination of federal and provincial health pro-
17 grams and for co-ordination of governmental efforts and
18 the activities of voluntary health organizations.

19 There is room for improved co-ordination of health
20 services at the regional level. And there is need for
21 more teamwork and mutual support among professional
22 and technical personnel: for example, through a direct
23 relationship between the isolated practitioner and the
24 modern hospital, or through group medical practice.

25 4. Problems of Standards and Quality

26 If the quality of Canadian health
27 services is to be as high as it should and could be,
28 there is need for the formulation of more effective
29 indices for measuring the nation's health level, this
30 refers back to the problem of information in one sense;
for the development and enforcement of better standards
of service and care; and for further public support



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and professional pursuit of quality in all its broad dimensions.

5. Problems of Payment

The problems of payment for health care and health services fall into three broad categories, as follows:

Payment for Hospital Care

Canada's hospital services program suffers from certain weaknesses and limitations, including the following, and these are just illustrations:

- a) In various provinces, contribution and residence requirements and/or exclusion of particular services or medications mean that the program is neither universal nor comprehensive.
- b) Removal of any financial barrier to needed hospital care has increased the pressure on Canada's hospital facilities; has created a risk of unnecessary hospitalization in individual cases; and may encourage an uneconomic and unbalanced development of the nation's health care facilities and services.

Payment for Other Health Services

Financial considerations still constitute a significant barrier to use of needed health services and facilities:

- a) Health care costs are very unevenly distributed within all income groups



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Payment for Other Health Services

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and facilities:

a) Health care costs are very un-



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and are unpredictable for the individual family.

b) In a financial sense, those who are most vulnerable in the event of illness are families in the middle and lower middle income ranges. If the illness is serious or prolonged, many such families must skimp on necessary health care; reduce their standard of living and/or incur debts; or do both.

c) Although the relative burden of health care costs is greater on average among low, than among medium or high, income families, it is doubtful if the former receive as high a quality of health care and services as the latter.

d) Although the largest components in total health care costs - aside from hospital services - are medical care, and drugs and appliances, other services such as nursing care may bulk as large or larger in individual cases.

e) Although a substantial proportion of Canadians now have protection against the impact of health care costs through various public and/or non-governmental programs, these programs, taken together, suffer from serious limitations in coverage of the population, extent of "covered" services, and proportion of

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the cost of "covered" services met
through benefits.

Payment of Health Care Personnel

Payment of health care personnel
involves two broad problem areas - the method of payment
and the amount of the compensation.

With regard to the first of these
issues - three different methods - fee-for-service,
salaries and capitation - are widely used, separately
or in combination, in Canada or elsewhere. Although a
variety of arguments are advanced in support of, and
in opposition to, each method, the Council has been
unable to discover conclusive evidence in favour of any
one of them. It is suggested in the circumstances that
the best approach probably lies in a mixture of different
methods of payment, with its possibility for flexibility
and experimentation and for shifts in the overall pattern
as circumstances and attitudes change.

Whatever the method of payment, the
amount of the compensation must be conducive to attracting
enough of the best qualified people into all the profes-
sional specialties that are essential to modern health
care. In this regard, two broad problems may be identi-
fied:

a) There is need for more careful
study of the monetary worth of the
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of inadequate remuneration.

b) There is also need for more careful
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rent groups within each profession.

In the medical profession, for instance,
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PART IV (Submission, Pages 45 - 69)

This section covers certain selected
services which in the experience of personnel working
in agencies that are members of the Council require
development.

One of the overall objectives which is
recommended above is a balanced development of all the
resources that enter into the provision of up-to-date
care. Out of its particular experience, the Council
directs attention in this regard to six services which
need strengthening. They are homemaker services,
organized home care programs, social work services,
chronic and convalescent services, rehabilitation services
and mental illness services. Administration of each of
these services today is partly a public responsibility
and is partly under voluntary auspices.

Regardless of the auspices of particular
programs, the Council recommends:

1. Increased acceptance of public
responsibility for the planning, financing, further
development, and co-ordination of these services across

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One of the overall objectives which is recommended above is a balanced development of all the resources that enter into the provision of up-to-date care. Out of its particular experience, the Council directs attention in this regard to six services which need strengthening. They are home-maker services, organized home care programs, social work services, chronic and convalescent services, rehabilitation services and mental illness services. Administration of each of these services today is partly a public responsibility and is partly under voluntary auspices.

Regardless of the emphasis of particular

programs, the Council recommends:

1. Increased acceptance of public responsibility for the planning, financing, further development, and co-ordination of these services



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Canada.

2. Further governmental leadership and financial support in the recruitment and training of the professional and technical personnel required to staff these services adequately. We refer in the full submission to the fact that the Federal Government has recently instituted a program of personnel training grants in the welfare field.

3. Incorporation of these services as constituent elements in any nation-wide program for payment of health care costs.

PART V (Submission, Pages 70 - 82)

NEEDED IMPROVEMENTS IN PLANNING AND ORGANIZATION

A. The National and Provincial Planning Task

Achievement of a balanced development in Canadian health care requires that responsibility for overall planning and co-ordination of services, public and voluntary, be clearly accepted and explicitly designated as a community responsibility.

This, in turn, means a need for further development in two broad directions. Governmental machinery - federal and provincial - for overall planning of health services and overall co-ordination of programs will have to be strengthened. And new machinery will be required to involve in this planning operation the voluntary health organizations, professional and technical personnel and volunteers in the health care field, and the consumer of health services, the general public.

The Council therefore recommends:

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tary health organizations, professional and technical

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Achievement of a balanced development

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PART V (Submission, Pages 10 - 22)

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3. The provision of these services as

forces in the welfare field.

recently instituted a program of personnel training

submission to the fact that the Federal Government has

staff these services adequately. We refer in the full



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appropriate, integration of health programs and services administered by separate departments or agencies of each responsible government, federal and provincial.

2. The strengthening of those federal and provincial departments that now have primary responsibility in the field of health care.

3. The fuller development of federal-provincial machinery for co-operation, and for co-ordination of efforts, in the planning and administration of health care programs.

4. The creation of broadly representative and adequately staffed national and provincial advisory health councils.

The health councils should have authority and responsibility to advise governments, the professions and the voluntary agencies and to report to the public, on a regular basis, concerning such broad aspects of health care policy as the following:

- a) Determination of unmet needs and the identification of problems;
- b) Formulation of goals and the allocation of priorities;
- c) Planning, organization and standards of administration of programs and services;
- d) Recruitment, training and distribution of personnel;
- e) Formulation and supervision of standards of service;
- f) Measurement and assessment of



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e) Formulation and supervision of

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f) Measurement and assessment of



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progress.

The health councils should be made up of representatives of the public and voluntary organizations and interests in the health field. Because of the interrelationship and overlapping of health and welfare, to which Mr. Fisher referred in his opening remarks, the health councils should also either include welfare representatives in their memberships, or develop workable machinery for liaison and co-ordination with welfare agencies, public and voluntary.

B. Regional and Direct Service Requirements

Although overall planning of Canadian health services can only be achieved effectively at the national and provincial levels, many of the organizational problems - gaps in service; overlapping and duplication of programs and facilities; inadequate or uneconomic organization of personnel and other resources; lack of communication, co-ordination and referral - are frequently most apparent and most pressing at lower levels. This also means a need for further development in two broad directions.

Specifically, the Council recommends:

1.a) The establishment or further development, since in some areas they are already established, of public regional health units, in order to encourage and ensure the planning, organization and co-ordination of "local" health services, public and voluntary, on a regional basis throughout the nation.

b) The creation of a regional advisory council - similar to the national and provincial advisory

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B. Regional and District Service Areas

Although overall planning of Canadian health services can only be achieved effectively at the national and provincial levels, many of the organizational problems - gaps in services; overlapping and duplication of programs and facilities; inadequate or uneconomical organization of personnel and other resources; lack of communication, co-ordination and liaison - are frequently most apparent and most pressing at lower levels. This also means a need for further development in the broad directions.

Specifically, the Council recommends:

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council - similar to the national and provincial advisory



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councils recommended above - in relation to each of
these regional health units.

2. Public planning and financial
support, national, provincial and regional, to foster
research and demonstration projects in the organization
and co-ordination of "local" health services; to support
the extension of proven improvements such as medical
group practice; and to ensure a more rapid adaptation
of all forms of organization as needs change and know-
ledge advances.



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These regional health units

are organized as follows:

1. The National Board of Health

2. The National Council on Health

3. The National Commission on Health

4. The National Conference on Health

5. The National Association of Health

6. The National League of Health

These advances



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A NATION-WIDE PROGRAM FOR PAYMENT OF
HEALTH CARE COSTS

The Need

The need in Canada for a nation-wide
program for payment of health care costs rests on certain
basic premises and significant features of the present
situation which are summed up in the following major
points:

1. An overall objective which is recommended in this submission is to make certain that everyone in Canada has unimpeded access to needed health services. No plan for the attainment of this objective should be deemed satisfactory unless it affords universal availability of required services; covers all the services which compose a recognized standard of comprehensive health care; makes possible a conscious effort to achieve an equitable distribution of the costs of covered services; protects the relationship between the professional person and the patient; and ensures adaptability and accountability in administration.

2. The objective of unimpeded access to needed health services and the objective of a balanced development of services of acceptable quality are inter-dependent. Whether through a single program or separate ones, the attainment of both objectives requires a nation-wide effort and approach.

3. The objective of unimpeded access cannot be attained through individual effort alone. Because the incidence of illness and disease is unpredictable and the cost of needed health services is very unevenly



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No plan for the attainment of this objective should be deemed satisfactory unless it affords universal availability of required services; covers all the services which compose a recognized standard of comprehensive health care; makes possible a conscious effort to achieve an equitable distribution of the costs of covered services; protects the relationship between the professional person and the patient; and ensures acceptability and accountability in administration.

The objective of unimpeded access to needed health services and the objective of a balanced development of services of acceptable quality are inseparable. Whether through a single program or separate departments, wide effort and attention.

3. The objective of unimpeded access cannot be attained through individual or group efforts. The incidence of illness and disease is unpredictable and the cost of needed health services is very uncertainly



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distributed, as we have noted above, many families are not in a position to budget for all the potential costs of health care on an individual basis.

4. Nor can the objective be achieved exclusively through private insurance plans. Although private plans, taken together, have made rapid progress in recent years, they are limited, with respect to the objective in five ways:

- a) They do not and cannot provide universal coverage of the population.
- b) Participation in private plans is by individual choice or, in the case of employer-employee plans, may be a condition of employment. In either situation, continuity of coverage can be a significant problem, especially in the event of recession or depression.
- c) Many private plans do not cover a comprehensive range of services and facilities.
- d) The amount of the benefits under private plans is frequently less than the full charge for "covered" services.
- e) Private plans are not designed to ensure overall equity in distribution of the costs of health care.

Three Proposed Approaches

The Council has examined three approaches to attainment of the objective of unimpeded access to needed health services for everyone. In the submission,



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4. "Can care be effectively be managed?"

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- c) Many private plans do not cover a comprehensive range of services and facilities.
- d) The amount of the benefits under private plans is frequently less than the full charges for "covered" services.
- e) Private plans are not designed to ensure overall equity in distribution of the costs of health care.

The Council has examined these five conditions to attainment of the goal of universal access to needed health services for everyone. In the submission,



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the three are given the titles of Public Subsidies or Allowances to Individuals and Families, Public Subsidies to Private Insurance Plans, and a Public Health Care Plan.

The approach of public subsidies or allowances to individuals and families involves the following characteristics and considerations:

It is assumed to be socially desirable and/or preferable that:

- a) Individuals and families should meet their health care costs directly, within the limits of their financial capacity to do so;
- b) In order to assist people to carry obligations beyond the limits of their own financial capacity, public authority should be used to re-distribute income rather than to provide the required services directly;
- c) Public action should be limited so as to leave as complete freedom of choice as possible both to those needing health care and to those providing it;
- d) If at all possible, a public monopoly in the payment for health services should be avoided.

A system of public subsidies requires some form of means testing which may be objected to on a number of grounds. A system of public allowances would require an income test, but with some 14 million or more Canadians already affected by public income testing in one form or another, it can be argued that an income test is less open to serious objection.

On the other hand, graduated health care allowances may have their own limitations. They could be discriminatory between individuals and families within



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 - c) Public action should be limited so as to leave as complete freedom of choice as possible both to those needing health care and to those providing it;
 - d) If at all possible, a public monopoly in the payment for health services should be avoided.

2. A system of public subsidies requires some form of means testing which may be objected to on a number of grounds. A system of public subsidies would require an income test, but with some 10 million or more Canadians already affected by public means testing in the form of another, it can be argued that an income test is less open to serious objection.

3. On the other hand, guaranteed health care allowances may have their own limitations. They could be discriminatory between individuals and families within



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any one income class. They could be a shifting and uncertain quantity for the individual family. And the appropriate size of the allowances - immediately and over the years - could be a serious problem.

4. Public subsidies and public allowances both separate the problem of payment for needed health services from the problems of production, distribution and pricing of those services. To some people, this is an advantage of the approach; to others, it is a weakness. Regardless of the merits of this issue, one effect would be a program of public expenditures without any direct public control over the costs which should determine the appropriate size of those outlays.

5. Neither public subsidies nor public allowances will ensure universal and comprehensive coverage of health care costs without some form of compulsion. If the individual or family is required to insure some or all of their health care costs with a private carrier, the effect is an indirect public subsidy to private insurance plans (see below for an analysis of direct subsidies to such plans). If the individual or family is compelled in some way to apply the subsidy or allowance to their own health care costs, the result, it can be argued, is an indirect type of public health care program. In either case, the vital element of individual responsibility and freedom of choice is to some extent diluted.

The approach of public subsidies to private insurance plans involves the following characteristics and considerations:

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Public subsidies and public allowances

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The approach of public subsidies to

private insurance plans involves the following characteristics:

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4 1. A program of public subsidies to private
5 insurance plans focusses on the problem of extent and
6 continuity of health insurance coverage. The objective,
7 broadly speaking, is to enable private plans to reduce
8 their premiums to a level where more people are able and/
9 or willing to purchase health insurance coverage. Given
10 the incentive of lower premiums, the individual is left
11 with complete freedom of choice - within the limits of
12 his means and other obligations - concerning the extent
13 and type of protection he should purchase.

14 2. Public subsidies to private insurance
15 plans do not involve government directly in the purchase
16 of health services or in the payment of health personnel.
17 The public authority would probably have to regulate those
18 private plans applying for subsidy by requiring, for
19 example, uniformity in conditions of membership, in
20 benefit provisions, and in procedures for assessing
21 claims. But any public action in the development and
22 allocation of health care resources could be kept separate
23 and distinct.

24 3. A serious problem in a subsidy system
25 is to determine what size of subsidy would be required to
26 encourage an approach to universal coverage and continuity
27 of coverage through private insurance plans. A related
28 difficulty is that, although a subsidy system would not
29 in itself require any test of individual means or income,
30 there would still be some families who were either unable
to afford the subsidized premiums or unwilling to purchase
protection and who might, therefore, have to fall back on
means-tested public assistance to provide them with needed
health services.

1. A program of public subsidies to private insurance plans focuses on the problem of extent and continuity of health insurance coverage. The objective, broadly speaking, is to enable private plans to reduce their premiums to a level where more people are able and/or willing to purchase health insurance coverage. Given the incentive of lower premiums, the individual is left with complete freedom of choice - within the limits of his means and other obligations - concerning the extent and type of protection he should purchase.

2. Public subsidies to private insurance plans do not involve government directly in the purchase of health services or in the payment of health personnel. The public authority would probably have to regulate those plans, for example, uniformity in conditions of membership, in benefit provisions, and in procedures for assessing claims. But any public action in the development and allocation of health care resources could be kept separate and distinct.

3. A serious problem in a subsidy system is to determine what size of subsidy would be required to encourage an approach to universal coverage and continuity of coverage through private insurance plans. A related difficulty is that, although a subsidy system would not in itself require any test of individual means or income, there would still be some families who were either unable to afford the subsidized premiums or unwilling to purchase protection and who might, therefore, have to fall back on non-insured public assistance to provide them with needed health services.



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4. Regardless of how the subsidy is
4 calculated, the public authority has no long-run control
5 over its size unless it freezes the amount and allows
6 rising prices of health services and shifts in their
7 utilization to force insurance premiums up or becomes
8 involved directly in the control of prices and/or
9 utilization.

10 The approach of a public health care
11 plan involves the following characteristics and considera-
12 tions:

13 1. Important advantage An important advantage of a public plan
14 to many people is that it would make possible the removal
15 of any economic barrier to needed health care.

16 2. Cost The cost of a public health care plan
17 would not be entirely a net addition to the nation's
18 health care expenditures; a large part of that cost is
19 currently being met through individual payment, health
20 insurance premiums, and a variety of public programs. On
21 the other hand, a public plan would mean a substantial
22 shift from the private to the public sectors of the economy.
23 The precise magnitude of the transfer is difficult to
24 estimate and a judgment as to its desirability is, in any
25 case, partly a matter of personal philosophy. But it
26 would undoubtedly have significant economic, social and
27 political implications.

28 3. Compulsion A public health care plan would involve
29 compulsion in that all persons or all persons in specified
30 groups were required to pay the premiums and/or taxes
related to it. A public plan should not, however, involve
compulsion concerning use of those types of health service
and care provided through it.



regardless of how the subsidy is allocated, the public authority has no long-run control over its size unless it freezes the amount and allows rising prices of health services and shifts in their utilization to force insurance premiums up or becomes involved directly in the control of prices and/or utilization.

The approach of a public health care

plan involves the following characteristics and considerations:

1. An important advantage of a public plan to many people is that it would make possible the removal of any economic barrier to needed health care.
2. The cost of a public health care plan would not be entirely a net addition to the nation's health care expenditures; a large part of that cost is currently being met through individual payment, health insurance premiums, and a variety of public programs. On the other hand, a public plan would mean a substantial shift from the private to the public sectors of the economy. The precise magnitude of the transfer is difficult to estimate and a judgment as to its desirability is, in any case, partly a matter of personal philosophy. But it would undoubtedly have significant economic, social, and political implications.
3. A public health care plan would involve compulsion in that all persons or all persons in specified groups were required to pay the premiums and/or taxes related to it. A public plan should, however, involve compulsion concerning use of those types of health services and care provided through it.



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4 4. A public plan may or may not involve
5 a direct contributory component (premiums or earmarked
6 taxes) in the method of financing; the use of co-insurance
7 and/or deterrent charges; and partial payment by the
8 consumer for any covered service. Adoption of one or more
9 of these features involves, it is suggested, a judgment
10 concerning the relative merits of two contrasting view-
11 points.

12 On the one hand, it may be argued that:

- 13 a) They would provide a necessary and
14 appropriate method for helping to underwrite the cost of a
15 public health care plan;
16 b) They would discourage unreasonable
17 demands and petty claims and, by directing the attention
18 of the public or the individual user to the cost of par-
19 ticular services, would encourage more responsible use.
20 c) They would be a useful way to reduce
21 wastage of time and talent of scarce professional personnel,
22 and to promote use of one kind of service or facility
23 rather than some alternative which was more expensive or
24 in shorter supply.

25 On the other hand, it is argued that:

- 26 a) Although a progressive premium may
27 be consciously aimed at achieving equity in distribution
28 of the financial burden, a level premium, co-insurance,
29 deterrent charges or partial payment may each be regressive
30 in their impact.
b) A premium system cannot be universal
because there will always be those who cannot afford the
premium and there will also be those from whom the amount



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4 of the revenue return is not worth the administrative effort
and cost of collection.

5 c) The burden of any system of direct
6 payment, small (co-insurance and deterrent charges) or
7 large (partial payment), will be heaviest on those who
8 need care the most, not necessarily on those with the
9 most ability to pay. A related point is that a direct
10 charge which deters one person will not necessarily
11 deter another.

12 d) Partial prepayment and/or direct payment
13 may involve relatively high administrative costs and, by
14 imposing an economic barrier in individual cases, may
increase the ultimate cost of needed health care.

15 5. A public plan makes possible a direct
16 connection between the method of payment for health care
17 and a balanced development and equitable distribution of
18 required facilities and services. How close this connec-
19 tion needs to be is a matter of debate. Some people
20 argue that, given a satisfactory solution to the problem
21 of provision and distribution of services, there are
22 several possibilities other than a public health care
23 plan for solving the payment problem. Other people take
24 the position that adequate solutions of the two problems
25 are, at best, unlikely without coordinated and compre-
hensive public action in both areas.

26 6. Under a public plan it would be desirable,
27 and should be possible, as at present, to use a number of
28 different methods, separately or in combination, to pay
29 professional and technical personnel in the field of
30 health care. The effect of a public plan on the amount of



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remuneration is likely to depend, in the final analysis, on the balance between public pressures to control overall costs, and the extent of financial inducement required to recruit a sufficient number and variety of professional and technical personnel.

7. The effect of a public plan on the quality of health care may likewise depend on the balance between two sets of forces. A government plan could be designed to encourage the development of a coordinated pattern of services, as well as a more equitable distribution of personnel and facilities. Government, it is also argued, is in a strong position to promote quality control and self-discipline by professional groups and to curb abuses of services by the consumer. A public plan could, on the other hand, foster uniformity at the expense of variety and adaptability; mediocrity and safety rather than bold experimentation and the pursuit of excellence. And a public plan, it is also claimed, would be likely to interfere with the patient's free choice of professional personnel and/or to weaken the professional-patient relationship.

Staging

Whatever approach is adopted to the objective of unimpeded access to needed health services, it may be necessary to proceed by stages in order to produce the services that would be required. In the determination of appropriate stages, the Council suggests the following guides:

1. High priority should be given to those services (for example, medical care) which a considerable

remuneration is likely to depend, in the final analysis, on the balance between public pressures to control overall costs, and the extent of financial inducement required to recruit a sufficient number and variety of professional and technical personnel.

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objective of unhindered access to needed health services. It may be necessary to proceed by stages in order to secure the services that would be required. In the determination of appropriate stages, the Council suggests the following actions:

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proportion of the population frequently require and of which the cost to the individual or family can be relatively burdensome.

2. The services given high priority should use existing personnel and facilities most economically and effectively.

3. Because the overall level of demand is likely to increase, at least initially, with unimpeded access to needed services, the order in which services are covered should be related to the adequacy of existing facilities and personnel.

4. Where the shortage of professional personnel is particularly acute, high priority should be given to those services (for example, dental care for children) that are most likely to prevent the development of more serious health problems. The illustration of dental care might also apply to No. 3.

5. Previous experience, if any, in the administration of controls and ease in establishing administrative machinery should be taken into account.

6. The method chosen to organize and finance those services which are given the highest priority should be such that further stages can be introduced, without major readjustments, to produce an integrated whole.

Findings

The problem of payment for health services is both complex and controversial. Many of the practical issues are difficult to assess. In some areas, the relevant facts are susceptible to divergent interpretation.

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4 In others, some of the pertinent facts are unknown and
5 may in certain instances be unobtainable. In addition,
6 the problem raises in acute form the philosophical issue
7 of the appropriate role and limits of the private and
8 public approaches to a social goal.

9 The Canadian Welfare Council embraces
10 in its Board of Governors, as in its membership, individuals
11 of widely-varying philosophy and conviction and a diverse
12 constituency of agencies and organized interests, public
13 and private, non-profit and commercial. In spite of
14 this diversity, there appears to be within the Council
15 a measure of agreement concerning four important aspects
16 of the problem of payment for health services, namely:

17 1. That the overall objective, as already
18 stated, should be that everyone in Canada has unimpeded
19 access to needed services;

20 2. That achievement of that objective,
21 as I have just indicated, may require the establishment of
22 priorities and progress by stages, in order to produce the
23 services that would be required;

24 3. That achievement of the objective
25 requires a nation-wide program for payment of health care
26 costs;

27 4. That, for the implementation of a
28 nation-wide program (as for the development of required
29 services), some measure of public responsibility and
30 initiative is essential.

There is not - given the nature of the
Council's membership - agreement concerning the exact form
and extent of public action that is required or concerning



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As a measure of agreement concerning four important aspects of the problem of payment for health services, namely:

1. Access to needed services;

2. That achievement of that objective,

as I have just indicated, may require the establishment of

priorities and progress by stages

services that would be required;

3. That achievement of the objective

requires a nation-wide program for payment of health care

4. That, for the implementation of a

nation-wide program (as for the development of required

services), some measure of public responsibility

initiative is essential.

There is not - given the nature of the

Council's membership - agreement concerning the exact form

and extent of public action that is required or concerning



the specific approach to a nation-wide program that would be preferable.

FUNCTIONS AND FUTURE ROLE OF THE VOLUNTARY HEALTH ORGANIZATION

Canada's voluntary health organizations, national, provincial and local, encourage and channel individual concern and community support for the improvement of health and health services in five main ways, as follows:

1. By identifying unmet health needs and problems and calling attention to gaps and weaknesses in existing health services and programs, they engage in Social Pioneering.

2. Voluntary health organizations may undertake Education Programs to stimulate public awareness of unmet health needs; to combat traditional convictions and superstitions about disease; and to promote community support of particular health services and public understanding and acceptance of new health procedures.

3. The voluntary organization may undertake or support Research and Experimentation in causes of disease, methods of treatment, organization of programs, and administration of services.

4. Some voluntary health organizations are directly involved in the Provision of Health Services, either to supplement public programs or in relation to new needs which the agency may have helped to identify.

5. By promotion of better health legislation, more effective public health programs and improved

the a self approach to a nation-wide program that would be preferable.

ment of health and health services in five main ways, as

1. Identifying unmet health needs and problems and calling attention to gaps and weaknesses in existing health services and programs, they engage in social engineering.

2. Voluntary health organizations may undertake Education Program to stimulate public awareness of unmet health needs; to combat traditional convictions and superstitions about disease; and to promote community support of particular health services and public understanding and acceptance of new health procedures.

3. The voluntary organization may undertake or support research and experimentation in causes of disease, methods of treatment, organization of programs, and administration of services.

4. Some voluntary health organizations are directly involved in the provision of health services, either to supplement public programs or in relation to new needs which the agency may have helped to identify. 5. By promotion of better health legislation, more effective public health programs and improved



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4 health services and facilities, the voluntary health
5 organization engages in what we called Social Action.

6 Whatever further steps are taken
7 concerning the related problems of payment for health
8 care and development of required services, the voluntary
9 health agencies will still have a vital contribution to
10 make with respect to the above functions. If the voluntary
11 agencies are to measure up to their challenge and
12 opportunity, however, means must be found to grapple more
13 effectively with the familiar problem of planning and
14 coordination of programs and services. The advisory
15 health councils which are recommended in this submission
16 should provide adequate and appropriate machinery for this
17 task.

18 Thank you, Mr. Chairman.

19 THE CHAIRMAN: Thank you very much,
20 Dr. Hougham.

21 Perhaps one or two general observations.
22 The nature of your submission patterns in a measure after
23 military appreciation in which you have posed the problem,
24 set out the arguments in favour of one set of views in
25 favour of one side and the views in favour of the other,
26 but not necessarily with any final or dogmatic answers.
27 That method is going to be very, very helpful to us,
28 because it does point up the arguments on the various
29 facets of the problem, and it is not just a case of being
30 black and white, the shading extends all the way across
the board, and the thought you have put into the prepara-
tion of this brief and the summary is going to be very
helpful to us.



Fisher

Perhaps just a word, a small discussion with you on the overall principle involved. I take it from reading your submission, and particularly from listening to the summation, you start with the proposition that good health is a national objective, to be achieved in some way or another, to be achieved by whatever method may best suit the Canadian people.

Have I stated that too simply or incorrectly?

MR. FISHER: Mr. Chairman, I think that is correct; again with the proviso that we don't think that health can be separated from other aspects of human welfare.

Before we continue, may I take a second to introduce a member of delegation who has just come in, Mr. W.M. Anderson, who is our Ontario Vice-President and for many years a senior voluntary official.

THE CHAIRMAN: We are quite happy to have Mr. Anderson join us as the summation was being read.

The attainment of good health, as you say, involves many things, but it includes preventive measures, health measures and many other social aspects such as good housing, good food, clothing and everything else; they are all rolled into one total. But if that is the accepted view, then is it your view that the attainment of good health is a national responsibility, is a State responsibility?

MR. FISHER: I don't think, Mr. Chairman, that perhaps we have separated the national government from the people of the community quite as sharply.



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Chairman, that perhaps we have separated the national

government from the people of the community quite as

sharply.



Davis 12109

MR. DAVIS: We would say a national-community responsibility.

THE CHAIRMAN: I have got to bring you to a little closer grips with the practical problem, whether it is a responsibility of Government.

DR. HOUGHAM: Mr. Chairman, I think in the submission we don't suggest this is an either-or proposition but a combined responsibility of Government. We see Government as having a role and an essential role, but we also suggest that voluntary organizations have an important role, and, as we indicated, one of the principles is that the individual or family has an important role and responsibility in this area.

If you are pressing us in specific terms of what are the responsibilities of each of these three groups, I think we indicate the responsibility of Government in the area of planning and ultimate development in the planning, coordination of services, working in cooperation with Provincial Governments and voluntary organizations.

THE CHAIRMAN: For this discussion we will stay out of the constitutional aspect and government will just be government and leave the matter of constitutional difficulties to take care of themselves.

Do you go so far as to say that the responsibility of the State is to make available services?

MR. DAVIS: I think this is to see that the arrangements are such that this end is achieved, the ultimate responsibility for seeing that this responsibility is achieved rests on the State.

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Hougham

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4 THE CHAIRMAN: That view has been
pressed on us by other organizations.

5 COMMISSIONER McCUTCHEON: Some of which
6 are not represented in the Canadian Welfare Council.

7 THE CHAIRMAN: That probably may
8 take us to a further development on it because if we
9 accepted the proposition that there was a state
10 responsibility to provide the services then there would
11 be the corresponding duty to find those service and
12 I wondered whether you had any views on that. I read
13 somewhere here, perhaps not too clearly, that the duty
14 of the medical profession, that the medical profession
15 has a duty to do such and such. I am concerned as to
16 whether we can translate this national responsibility,
17 if it does exist, and put it on the shoulders of the
medical profession.

18 MR. DAVIS: Not without supervision,
19 I would say, by the community.

20 COMMISSIONER McCUTCHEON: What do
21 you mean by supervision by the community?

22 MR. DAVID: I mean health is too much
23 of an affair of national interest to turn it over to
24 any one group however well qualified technically or
25 high minded socially, that it is a community responsibility
26 and that the ultimate responsibility cannot be delegated
27 to a particular group which might, in the pursuit of
a social objective, be influenced by its own self
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28 THE CHAIRMAN: It has been said that
29 if legislation should be passed setting up a form of
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3 organization that would require medical services to be
4 given that there is a moral obligation on the medical
5 profession to perform those services. Do you accept
6 that as a valid basis?

7 MR. FISHER: There are so many
8 qualifications in this. I do not want you to feel we
9 are ducking the answer but I think the answer would be
10 from the point of view of the Welfare Council that the
11 medical profession has a responsibility for doing their
12 share. On the other hand, the community has a
13 responsibility to provide an overall framework within
14 which the medical profession can operate satisfactorily
and with reasonable satisfaction to itself.

15 THE CHAIRMAN: Well, where does this
16 duty arise, from whence the duty to do its share. Why
cannot it just sit and serve as a profession?

17 DR. HOUGHAM: It would seem to me the
18 answer should not be given by the Canadian Welfare
19 Council but the medical profession. All the human
20 professions recognize an obligation, an obligation or
21 responsibility to provide services to the people, not
22 to withhold services to the people. In the medical
23 profession this is also illustrated by the fact that
24 a doctor, as I understand it, will not refuse service to
a patient if he cannot afford to pay for the service.

25 THE CHAIRMAN: That is quite true but
26 we are not postulating the proposition from the fact
27 they have been doing it and say because they have been
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Hougham

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4 MR. ANDERSON: A moment ago you asked
5 about the individual responsibility for the provision
6 of service and I think the general sentiment within the
7 Council is that government now is in fact providing
8 a good many health services of certain kinds to certain
9 people in certain areas. I do not think there is any
10 difference of opinion that in the case of any particular
11 element of the health service program that the question
12 of whether it should be publicly provided or privately
13 provided is a question to be solved on its merits, the
14 problem is one which involves not whether the government
15 provides the service but the government should purchase
16 the service. I think in the Council there is a divergence
17 of opinion as to this kind of action. There are a
18 number of people who feel that under conditions where a
19 government becomes the sole purchaser or the principal
20 purchaser of service there is no difference between the
21 purchase of service by a single purchaser and the
22 providing of that service by a single purchaser. I suggest
23 that the reaction against the program of this kind is
24 largely to the effect that there has been no direct
25 decision taken for government to provide service with
26 the interim decision where government purchases services
27 will in the long run constitute a process of government
28 providing service within it. This was not intended.

29 THE CHAIRMAN: You see even in the
30 contention where the government becomes the purchaser
of service, I am putting the proposition, is there a
moral obligation on anyone to sell his services to the
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MR. ANDERSON: A moment ago you asked

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Anderson

12113

MR. ANDERSON: This is getting a way beyond the field of health, is it not?

THE CHAIRMAN: Well, it is not beyond the discussions we have had.

COMMISSIONER McCUTCHEON: And not beyond the terms of reference of the Commission.

MR. ANDERSON: If government sets itself up to be the sole purchaser of the particular service ---

THE CHAIRMAN: We do it in terms of national defence, we came to it eventually. Twice in our history we had to come to that stage.

MR. ANDERSON: It seems to me a very good case could be made for taking the view that the citizen is in the position of a government to be the sole purchaser of a particular service which in effect in its wisdom is prohibiting the purchase of that service otherwise.

COMMISSIONER McCUTCHEON: I was not present on the hearings on Tuesday afternoon or yesterday and I received this brief a little earlier than the other members of the Commission. I spent ten hours on an aeroplane and during that period I had the opportunity to read the brief as well as the summary. Now, in reading the brief alone, leaving out the qualification which starts at the foot of page 21 referring to the diversity of opinion and the diversity of the interest, of the interests of the members of the Council and its Board which is the one thing that is not included in the brief, reading the brief alone without the summary, without that qualification, without what you have said, accepting



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5 programs are there but I would describe this document
6 as an objective document which leads to the absolute
7 conclusion that the only solution for our health problems
8 in Canada is a national comprehensive compulsory plan
9 to be financed out of general taxation. Now, is that
10 the Council's position?

11 MR. FISHER: I think the answer to
12 that is no.

13 COMMISSIONER McCUTCHEON: All right,
14 what is the Council's position?

15 MR. FISHER: Mr. Chairman, the Council
16 is a very human organization and I think you have to
17 begin with this. When we prepare a brief of this sort
18 we cannot be guided entirely by logic and facts, we
19 also have to be guided by politics and when I say politics
20 I mean the divergent interests and points of view of
21 people in our organization. While there is logic in
22 the report and there are facts in the report there are
23 also compromises in the report. We tried to reach a
24 consensus at the highest level.

25 COMMISSIONER McCUTCHEON: Would you
26 quarrel with the conclusion I draw from reading the
27 brief without the benefit of the qualification in the
28 summary?

29 MR. DAVIS: I would leave it to the
30 intelligence of the Commission to draw its own conclusions
on the basis of the analysis we tried to provide and
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Davis

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7 and our problems.

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COMMISSIONER McCUTCHEON: Well that
is the conclusion I reach and I have been told it is not
the view of the Council. Let me ask another question;
why in the statements made by Mr. Fisher, Mr. Davis
and Mr. Anderson that this is a problem, the responsibility
of the community, and you have said it is the responsi-
bility, I think Dr. Hougham said the responsibility of
the family and the individual, reading this document
it seems to me that you are attempting to relieve the
individual of any responsibility. The inevitable
conclusion is that no one should pay directly for his
own health care, that is regressive. I suppose if we
pursued the matter, and I do not think you want to,
you would say if we had a national health scheme and
financed it by a sales tax that would be regressive.
You talk about equitable burden of health care, well
now, how far -- you say it is inextricably wound up with
welfare, you cannot separate the two. Now, are you to
have an equitable burden of buying food, an equitable
burden of providing housing, are we to assume the burden
of clothing ourselves equitably? Why do you take the
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Davis

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3 of providing for them than we do when we provide for
4 some group with other necessities of life such as food,
5 clothing, housing?

6 MR. ANDERSON: I think there is an
7 important reason that this problem is very different
8 from everything else. In the first place, I think it
9 can be taken for granted that the Council's approach is
10 one of endeavouring to relieve individuals of responsi-
11 bility when those responsibilities are beyond their
12 capacities. The question of the extent to which that
13 course of action may involve you in relieving the
14 people of responsibility that are within their capacities
15 is something that theoretically you might want to avoid,
16 practically you may not be able to do that. The reason
17 why this problem is different from all others is that
18 in the first place health care or what would be regarded
19 as a publicly acceptable standard of health care is by
20 far the most regressive of all types of consumer
21 expenditure in the sense it is virtually independent
22 of income, as the costs of adequate health care are
23 quite independent of income which is hardly true of any
24 other significant consumer expenditure. The other
25 point is that coupled with this extreme regressibility
26 is a high degree of unpredictability in the sense that
27 health care might have costs that fall between families
28 and individuals and it is the awkward combination of
29 those two things, the extreme regressiveness and the
30 cost of an adequate standard of health care along with
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of providing for them than we do when we provide for some group with other necessities of life such as food, clothing, housing?

MR. ANDERSON: I think there is an important reason that this problem is very different from everything else. In the first place, I think it can be taken for granted that the Council's approach is one of endeavoring to relieve individuals of responsibility when these responsibilities are beyond their capacities. The question of the extent to which that course of action may involve you in relieving the people of responsibility that are within their capacities is something that theoretically you might want to avoid, practically you may not be able to do that. The reason why this problem is different from all others is that in the first place health care or what would be regarded as a publicly acceptable standard of health care is by far the most regressive of all types of consumer expenditure in the sense it is virtually independent of income, as the costs of adequate health care are quite independent of income which is hardly true of any point is that coupled with this extreme regressivity is a high degree of unpredictability in the sense that health care might have costs that fall between families and individuals and it is the awkward combination of those two things, the extreme regressiveness and the cost of an adequate standard of health care along with the high unpredictability of the individual that makes the problem so difficult to solve because there is no parallel in any other area.



Anderson

12117

THE CHAIRMAN: Isn't there in life itself?

MR. ANDERSON: You get high unpredictability. For example, you die. You get unpredictability in other areas too but you do not get the combination of the two problems, Mr. Chairman. Take the case of the breadwinner facing a risk of death. Certainly it's unpredictable but nevertheless the risk that he faces - and his problem is directly geared to the size of his income.

Low income, the loss of income through his death is low.

THE CHAIRMAN: It's just as complete.

MR. ANDERSON: With high income he buys the amount of insurance which is prepared to replace his income.

THE CHAIRMAN: Are you suggesting that the State should buy the insurance for him?

MR. ANDERSON: No, I am not saying that. I am saying that the combination of these two things makes the problem different from other problems, sir. One cannot draw an analogy directly with any other type of consumer expenditure and expect the analogy to fit.

THE CHAIRMAN: That is fair enough.

MR. ANDERSON: We have other expenditures, such as food and rent, which are fairly high regressives. Nevertheless, they are not unpredictable. We have other unpredictable expenditures such as the problem of becoming disabled. The loss of income through that.



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12118

The problem of dying. The loss of income through that, but in general these are not highly regressive in the sense that the loss is commensurate with income. His insurance is also commensurate with the income.

Here we have got the two things linked together. Extreme regressiveness of the cost of adequate health care, in the sense it is more or less independent of income, together with the high unpredictability which suggests to me that no solution can be found where there is not some kind of intervention from outside in respect of a substantial element of the population.

Now, in the case of the employed population, it is possible, with that kind of intervention at the level of the employer, and there are instances, of course, where health care insurance is provided under conditions where the employee's contribution is graded according to income and the employer picks up the remainder. It's that kind of action that seems to be necessary in order to solve the problem.

MR. FISHER: Mr. Chairman, before we get too far, may I invite Mr. Racine if he would care to say a few words from the point of view of his group?

THE CHAIRMAN: Yes, indeed.

MR. RACINE: Monsieur le président, messieurs les commissaires, mademoiselle Girard, étant le représentant de langue française, président de la Commission française du Conseil Canadien du Bien-Etre, le mémoire du Conseil a été préparé en tenant compte de l'opinion de ces membres d'expression française.

Une grande partie de ces problèmes



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get too far, may I invite Mr. Racine if he would care to say a few words from the point of view of his group?

MR. RACINE: Monsieur le président, messieurs les commissaires, mademoiselle Girard, étant le représentant de langue française, président de la Commission française du Conseil Canadien du Bien-Être, le mémoire du Conseil a été préparé en tenant compte de l'opinion de ces membres d'expression française. Les grands partis de ces problèmes



Racine

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sociaux provenant due fait qu'au foyer il y a de la maladie et résultant de tout cela, des dettes accumulées, une partie du salaire amenant souvent des divisions au foyer et des problèmes que doivent régler les agences sociales.

La page 7 du sommaire - Le problème mentionné dans ce paragraphe est peut-être plus aigu dans les centres de langue française où existe une pénurie de travailleurs sociaux de langue française, tout spécialement dans les milieux de langue française en dehors du Québec.

THE CHAIRMAN: Monsieur Racine, nous sommes heureux de vous entendre nous adresser dans la langue française et heureux de vous voir

The problem you mention of the lack of social workers in the various fields, particularly in those of the French language outside of Quebec, of course, is common with all the other groups in Canada because we have heard there is a shortage every place and of every kind.

As you did say, by and large the brief represents your views as well as that of your group.

MR. RACINE: That is right.

COMMISSIONER McCUTCHEON: The suggestion is made, at least I read the suggestion here, that the Government, as the purchaser of the service, will provide adequate and high quality services to an extent that other purchasers or a variety of other purchasers will not be able to obtain and there is a reference to the fact it's the limitation of income probably that



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Fisher

12120

prevents the appropriate recruitment into the nursing profession and the social work profession.

Now, we had a brief from a group of government employees in Ottawa on behalf of the nurses in the government services and the Government of Canada is the largest single employer of nurses in this country and in that field, at least, it has done nothing to increase the remuneration in order to aid recruitment.

Is there any reason to believe that if this whole problem is to be put into the field of government that it won't simply become another budgetary item and compete with roads and sewers and causeways and other things? You have had a great deal of experience.

MR. FISHER: You see, Mr. Chairman, we come back to this problem of representing the Canadian Welfare Council. I must here today represent the aggregate synthesis of Council's thinking and not my own personal reaction. I do not want to get into a discussion with Mr. McCutcheon, either again him or with him. Here, I am the Canadian Welfare Council representative.

COMMISSIONER McCUTCHEON: I think that answers my question.

DR. HOUGHAM: Mr. Chairman, there is a point that could be added here in that, as far as I am aware, and I have had as much to do with the preparation of this brief as anyone, we never make the point that Mr. McCutcheon has made which is that the Government would be the purchaser of the service.

The point we make in regard to quality is that there is a community and an element of public



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Hougham.

12121

responsibility to work towards the service of acceptable or high quality. This is not necessarily to say that in order to do this all services must be either provided through government or purchased by government.

To come back to Mr. Anderson's point, this is a responsibility in relation to standards which we are emphasizing here.

THE CHAIRMAN: You see, the point is, this is what has been urged upon us, that acceptance of the principle is a State responsibility. In the health field that has been put forward that that inevitably leads to making the Government the sole purchaser of the services. That it will inevitably - maybe not today or tomorrow - but that it is inherent in the proposition itself that no other result could come about.

MR. FISHER: Mr. Chairman, you make us feel that we are being much less helpful than we should be. Some of us would answer your question in the affirmative and others would answer your question in the negative. I don't think that in fairness to the other members of the Council we can answer your question.

THE CHAIRMAN: It is not our intention to be embarrassing in this sense.

MR. ANDERSON: We have other areas where government has assumed responsibility for the quality of a product through State supervision, regulation and even control, without being involved itself in the production of that product or the purchase of it.

THE CHAIRMAN: If this is to be a tax-



13121

Houghton

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 THE CHAIRMAN: Is this to be a tax-

28
29



Anderson 12122

supported program it would be involved.

MR. ANDERSON: The point that I have made, sir, was a little different. It was to the effect if government becomes the sole or principal purchaser of the service, that this would lead to the Government providing the service but I am not making the point it was necessary for government to become a major provider or a major purchaser in order to supervise and regulate the quality of the service.

DR. HOUGHAM: Now, Mr. Chairman, I think the point can be added here - I seem to recall Mr. Anderson mentioning this point in an earlier discussion with me - even under a so-called public program, such as in Great Britain, there is a good deal of service which is still privately purchased. If you are going to talk about a public program it doesn't necessarily imply that the Government would be the sole or even the predominant purchaser of the service.

COMMISSIONER McCUTCHEON: You are not suggesting that the Government is not the substantial - that there is not an appointee, I think that is Mr. Anderson's word, in the health field in the United Kingdom?

MR. ANDERSON: There is in the case of the general practitioner.

COMMISSIONER McCUTCHEON: Certainly.

MR. ANDERSON: The general practitioners, in general, in Britain, are civil servants.

COMMISSIONER McCUTCHEON: Those of them that are not on the dole.



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Davis

12123

MR. DAVIS: Is this an objective
Commission at the moment?

COMMISSIONER McCUTCHEON: Very objective.
Is it fair to say ---

THE CHAIRMAN: Is that observation a
fair one?

COMMISSIONER McCUTCHEON: Any observa-
tion Dr. Davis makes about me is fair.

THE CHAIRMAN: If it is limited to you
I would not have felt it necessary to involve those who
have been silent here.

COMMISSIONER McCUTCHEON: Is it a fair
statement, Mr. Fisher, that what the Council has done
here is to set out the absolute ultimate ideals of what
they would like to see in the way of health service in
Canada and if they are to be available to all; I notice
the homemaker service should be available to everybody.
I am not going to discuss the difficulty of making the
homemaker service available in a very large section of
this country, no matter who undertakes it, to make it
available and so on.

You list a great variety of services
that should be universally available. What the Council
has done is to say that this is the ideal situation.
How it is to be done, who is to do it, who is to pay for
it, we are saying nothing.

MR. FISHER: I don't know that we
would even actually say this is the ideal situation.
Unfortunately, this is a tremendously complicated
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12113

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working under great time pressure. We have had to get something down which we have formulated and present some synthesis of our thinking.

I think that if we had another year to play with this that there might be a good many clarifications worked into this brief. When Mr. McCutcheon asks if we don't care how it is done, I don't think this is true.

COMMISSIONER McCUTCHEON: I did not say you don't care. I say you are not saying.

MR. FISHER: At the moment we are not saying. That is perfectly true.

COMMISSIONER McCUTCHEON: That is the point I was making.

MR. FISHER: It's apparent, I think, we have been faced with the difficulty of working under great time pressure and perhaps we have some reservations as to whether we have really done the whole thing justice with the time at our disposal.



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THE CHAIRMAN: Perhaps I might say that the reason we are bringing these provocative questions and discussions before you gentlemen is because in our judgment we didn't think there was a more representative, or more capable group with which these very serious questions should be discussed, and I think I must say this in relation to what Dr. Davis has said. We are trying to be an objective commission, and it is when we seem to be at variance with people who have some pet theories that the notion arises that we may not be being completely objective, and it is because we want to hear all sides of the question that we are probing, and not making any forecast of what we are going to ultimately do or recommend.

MR. ANDERSON: Mr. Chairman, if you will refer to the bottom of page 114, there is a little footnote there which indicates that we didn't explore all suggestions that have been advanced as to methods of solution of this problem of payment. In particular, there is reference to the fact that we have not examined the possibilities of a public plan confined to coverage of catastrophic costs. Nor does it assess either public payment of a direct fraction of all health care costs, or direct public subsidy of health programs and services.

The point I wanted to make was that the things we did examine were illustrative of the approaches that have been examined. Our process of examination was designed to bring out differences of view pro and con. It is conceivable that had we had

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Anderson

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4 of these other approaches that are merely footnoted,
5 that we might have reached conclusions in this area
6 which we were unable to reach.

7 ~~alternatives.~~ THE CHAIRMAN: You see Mr. Anderson,
8 we come to page XIV, that is part 6, item 4, and then
9 there are a number of things spelled out, and it finishes
10 up with:

11 "Private plans are not designed to
12 ~~inter-upt the~~ "ensure overall equity of distribution--",
13 et cetera. Well, we had before us a group of what
14 did appear to be highly respected and competent
15 gentlemen from the insurance fraternity, who came forward
16 saying that they believed that machinery could be worked
17 out which would accomplish this thing. Now, I don't
18 know if in the preparation of this you have given any
19 consideration to what these other briefs have been?

20 MR. ANDERSON: Yes we have.

21 ~~different~~ THE CHAIRMAN: And Mr. Fitzhugh and
22 these other gentlemen were here about a week ago, saying
23 that they could do exactly what your brief is saying
24 that they cannot do. We are just trying to find out ---

25 MR. ANDERSON: All we have said here
26 is that the objective cannot be achieved exclusively
27 through private plans. The brief that you are mentioning
28 didn't say that it could handle the problem exclusively.
29 It not only admitted that there were some parts of the
30 problem that it couldn't tackle, but it also said that
in order to tackle as broad an area as suggested legisla-
tion would be required. In other words, there would have



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3 to be enforced pooling of substandard risks.

4 THE CHAIRMAN: Or the suggestion I
5 made of the subsidization of that pool by government.

6 MR. ANDERSON: That would be the
7 alternative.

8 THE CHAIRMAN: Which might obviate the
9 necessity of all this enabling provincial legislation.

10 MR. ANDERSON: But in any event their
11 suggestion was along the line of saying without the
12 intervention of government a great deal of this problem
13 can be handled satisfactorily. Nevertheless to complete
14 the solution of the problem there must be parallel
government action, at least in certain areas.

15 THE CHAIRMAN: Well, they recognize
16 that the premiums of those who are unable to pay would
17 have to be paid by government.

18 MR. ANDERSON: That was separate.

19 THE CHAIRMAN: Yes, but that is no
20 different from what a hundred others have said. That
21 when a person isn't able to pay for himself, and you are
22 going to give him service somebody is going to have to
pay, for it.

23 COMMISSIONER McCUTCHEON: Nobody has
24 come here and said that the person who cannot afford
25 health care should be prevented from obtaining it by
26 any economic barrier. No group whatever has said that.
27 Every group that has appeared has admitted that that
28 portion of the population must be taken care of, and
29 there is only one medium to take care of it, and that is
30 government, without going into whether that is federal,



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Anderson

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provincial or municipal government.

The question that interests us is in order to take care of that group you have to remove the responsibility of taking care of themselves from all the other individuals in the population. Now, that is the real question.

THE CHAIRMAN: Is that the only way of accomplishing it? To provide for those who cannot help themselves we must provide for everybody?

MR. ANDERSON: If you take a narrow definition of the people who cannot help themselves. There are still several different ways in which the problem can be dealt with for them by government. There is the method of means testing at the point of service. There is the further method, which is used in certain countries, of the setting up of a free public health service. That is public provision of service for people who cannot afford to purchase it, and of course in some countries the direct provision of the service by government designed for the lowest income classes very often is made available to everyone who wishes to use it, although it is not normally used except by people who decide themselves that they cannot pay. Jamaica is a good example, where there is a comprehensive health service provided by the government for the entire population, but it is only used by people whose incomes are low.

COMMISSIONER McCUTCHEON: Is that a sign of poor service?

MR. ANDERSON: No, I think it is a matter of personal prestige.



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Anderson

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4 COMMISSIONER McCUTCHEON: A gentleman
5 who came before us from the western provinces said
6 there should be no means test for anybody. If he wanted
7 a hundred dollars he should be able to go into the
8 welfare office and get it, and that would be humiliation
9 enough without any further enquiry.

10 MR. ANDERSON: The problem is not as
11 narrow as some people would be inclined to define it.
12 Even if it was a somewhat broader area it is my own
13 personal opinion that there is no necessity whatsoever
14 of saying that the process of providing for a totality
15 of health services should be dictated by the presence
16 of a comparatively minor problem area.

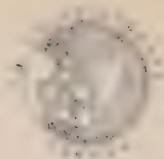
17 COMMISSIONER VAN WART: On page 101 --
18 you are the first group that appeared before us who have
19 broken down this question of compulsion. You state that:

20 "Compulsion of course can refer only
21 "to contributions and not to benefits".
22 As you are the first group to bring this before us, I
23 wonder if you can enlarge a little on that?

24 MR. FISHER: Mr. Chairman, I am not
25 quite sure --- Certainly we mean there that we didn't
26 visualize in Canada the idea of a man simply being told
27 that if you are sick you have got to go to this doctor,
28 through this process, and we prohibit you from going
29 to anyone else.

30 COMMISSIONER VAN WART: Well, I mean
if he does not want to take the benefits, that is his
business, not the State's?

MR. FISHER: Yes.



COMMISSIONER McCUTCHEN: A gentleman

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Hougham

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4 DR. HOUGHAM: It seems to me that
5 there is an analogy here, which I will not press, with
6 the educational system, where everybody is required to
7 pay the taxes that support a public system, but it does
8 not force you to send your children to a public school.

9 THE CHAIRMAN: It does not force you
10 to have children?

11 COMMISSIONER VAN WART: The children
12 must be educated though.

13 DR. HOUGHAM: That is why I say we
14 will not press this analogy too far. There is this
15 distinction with education. Education is a public
16 requirement. It is hard to visualize, and I don't think
17 the Council would recommend that you make the use of
18 health services compulsory.

19 COMMISSIONER McCUTCHEON: You are
20 recognizing the human factor that people can well afford
21 to refrain from going to the dentist or the doctor for
22 their own personal reasons. You are not going to force
23 them to?

24 DR. HOUGHAM: That is right.

25 COMMISSIONER VAN WART: If people don't
26 take advantage of the benefits, then the system falls
27 down, doesn't it?

28 MR. ANDERSON: There is a distinction
29 here also that can be easily seen in the case of hospital
30 plans between the provinces that have not used a so-called
premium system, and the ones that have. In the provinces
not using a premium system, it seems difficult to use
the word compulsion in describing those plans if the



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DR. HUGHES: It seems to me that

there is an analogy here, which I will not press, with the educational system, where everybody is required to pay the taxes that support a public system, but it does not force you to send your children to a public school.

THE CHAIRMAN: It does not force you

to have children;

COMMISSIONER VAN WART: The children

must be educated though.

DR. HUGHES: That is why I say we

will not press this analogy too far. There is this

distinction with education. Education is a public

requirement. It is hard to visualize, and I don't think

the Council would recommend that you make the use of

health services compulsory.

COMMISSIONER MONTGOMERY: You are

recognizing the human factor that people can well afford

to refrain from going to the dentist or the doctor for

their own personal reasons. You are now going to force

them to?

DR. HUGHES: That is right.

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4 province in its wisdom, in co-operation with the Federal
5 Government, has really made the health services available
6 without price to the totality of the population. In a
7 province like Ontario, where the action has been in
8 between, one can argue that the premiums are compulsory
9 for the segment that has to pay them. That the premiums,
10 although voluntary for the people who are not directed
11 by law to pay them, virtually become compulsory because
12 of the extreme potential penalty if you don't buy. So
13 the pattern in this province has been one where there
14 has quite clearly been compulsion, if you want to call
15 it that, levied on the financial side, but certainly
16 not on the service side.

17 COMMISSIONER BALTZAN: Gentlemen,
18 across the country I have been trying to get some
19 clarifications and some type of differentiation, and I
20 put to you the following proposition.

21 Number one, does your experience show
22 that poverty, or low earnings, is conducive to disease
23 or ill health? When one is in the low bracket, et cetera,
24 that there is more sickness?

25 DR. HOUGHAM: Without attributing cause
26 and effect, I think there is no doubt that there is a
27 correlation between income and health.

28 COMMISSIONER BALTZAN: Number two,
29 does your experience show that disease or ill health is
30 conducive to poverty or low earnings?

DR. HOUGHAM: Yes.

COMMISSIONER BALTZAN: The reason why
I put these two things together is that both of these



province in its wisdom, in co-operation with the Federal Government, has really made the health services available without price to the totality of the population. In a province like Ontario, where the action has been in between, one can argue that the premiums are compulsory for the segment that has to pay them. That the premiums, although voluntary for the people who are not directed by law to pay them, virtually become compulsory because of the extreme potential penalty if you don't pay. So the pattern in this province has been one where there has quite clearly been compulsion, if you want to call it that, levied on the financial side, but certainly not on the service side.

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Medical services, I ask you, are not necessarily alone
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COMMISSIONER BALTZAN: Lastly, one might deduce that, rather than concentrating, say, on medical services altogether, one might have to consider that the dollar insufficiency for putting it in general terms of living conditions appears to be an important aetiological, causative factor in disease or ill health at certain levels. In other words, if the standard of living and the things Mr. McCutcheon referred to were ample, the element of medical services would be considerably eliminated at that particular stratum or level. Is that a fair deduction?

DR. HOUGHAM: Mr. Chairman, I would like to take the first crack at answering this proposition. In reading the summary I left out a key sentence on the question, and it is on Page 4, under the first underlined section, where we have enunciated three broad objectives, if you like in Mr. McCutcheon's terms, ideals in this area, the first of which is "To keep to a minimum the incidence of illness and the need for treatment services by assuring an adequate standard of living for all Canadians," and so on, and then we go on to say: "Better health and more adequate health care for Canadians demands simultaneous progress toward all three objectives." And we suggest some requirements related to the achievement of the first objective, the continued efforts to eradicate poverty and raise the standard of living. I don't think the Council is making a choice in raising the standard of living and health care services. I think I would be speaking personally here rather than for the Council, but at the level of



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health services it would seem to me that a choice might be made in the sense that I find it rather difficult to conceive a rather civilized community put a dollar-value, let's say, on a long-range program to raise the standard of living than on services people need today. If you are sick, you need medical care.

COMMISSIONER BALTZAN: That wasn't exactly my question, which was to equate the dollar-value versus the human needs value. My point was, so many things being considered from the point of view of deficiencies, shortages in terms of health services, it is actually partly due to deficiencies, say, in the welfare area, and I mentioned before that the whole thing seems to be lumped.

MR. RACINE: Mr. Chairman, I don't think it is a warranted conclusion, that is, if income and family situation were ample would this lead to a lowering of health needs. I suggest that while it may lead to a lowering of welfare needs, it might lead to a raising of health care expenditures. It is quite obvious that the health care expenditures of the higher income groups are considerably greater than the cost per capita of an adequate standard of health care. People, as their incomes increase, manage to find ways in which to spend what they earn, content to spend on health care, even though they don't need it.

COMMISSIONER BALTZAN: That's not the whole answer for the differential.

MR. FISHER: Mr. Chairman, there is corollary. Mr. McCutcheon said that nobody answered



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COMMISSIONER McCUTCHEON: I am glad you said that. I refrained from saying it.

MR. RACINE: All the cross-section studies I have seen for other countries indicate that the family expenditures for people on health care are very closely conditioned by income. You can go back over a century and look at countries like Britain, Germany and other European States, and it seems to be the case that people are prepared to devote about one dollar in twenty-five to voluntary expenditures on health care, on the average at each income level.

COMMISSIONER BALTZAN: Some people have advocated the separation of the Department of Health and the Department of Welfare. Under the circumstances it seems like a fairly appropriate constitution in relation to the problem at hand, that these two are intimately inter-related.

MR. FISHER: Mr. Chairman, this is one thing on which I think all the members of the Canadian Welfare Council are completely unanimous.

THE CHAIRMAN: Just one statement, on Page 20, just before "staging", in Paragraph 7. "Government, it is also argued, is in a strong position to



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promote quality control and self-discipline by professional groups and to curb misuse of services by the consumer." I know this is stating one argument in terms of another, but have you any observations to make on that? Is it accepted that the Government would be in a position to have quality control?

MR. FISHER: In the next sentence there is an alternative side of the coin.

THE CHAIRMAN: Yes, it is a statement on one side as opposed to the other.

MR. FISHER: Well, certainly in the welfare field it is on record, cases of leadership in raising standards and improving services by Governments.

THE CHAIRMAN: On Page 8, you referred, Dr. Hougham, to indices, and I made mention that we have already set the machinery in motion with the Bureau of Statistics and the Department of Health, getting them together to try to find a basis for a much more complete index or indices of health in Canada; several months ago this thing was set in motion.

DR. HOUGHAM: All we had in mind, speaking for the special committee who prepared the first draft of this brief, is that we constantly hear the argument that Canada has the highest standard of health care in the world, and when you look at indices you start to discover weaknesses in them, and so on.

THE CHAIRMAN: Yes, and that has already been looked into quite thoroughly by the Bureau of Statistics and the Department of Health and Welfare.

Are there any further observations?

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This is no holds barred.

MR. FISHER: Mr. Chairman, we have greatly overstayed our time, and certainly I would like to make the observation that we are intensely grateful to you for the careful attention you have given to our submission, both now and in the fact that this has so obviously been read and studied by the Members of the Commission.

THE CHAIRMAN: This is not by way of criticism, but we didn't receive it soon enough perhaps to have made the thorough study we would have liked to be able to do. But we have it and we will have it with us, because, as I said before, I don't think that there is any organization to whom we have looked for guidance and for help, and we are grateful to you for the submission and for the manner in which it is done, in putting forward these views. Whether one or more may agree with them or disagree with them, they are here in black and white and they will be before us as we meet to consider what we can do, because ultimately, as you will appreciate, it is a decision, perhaps a philosophical decision, that has to be made as to what the approach is and not necessarily being bogged down in details. Once an overall decision is made, I have no doubt means can be found; we can't be that lacking in ingenuity that we can't work out a program if the country decides that this is the course we should follow.

We are very grateful to you for your help.

MR. FISHER: Thank you very much, sir.

THE CHAIRMAN: We will take a short recess.



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THE SECRETARY: Mr. Chairman, the next
submission is from the Social Planning Council of
Metropolitan Toronto and will be known as Exhibit No.
357.

--- EXHIBIT NO. 357: Submission of the Social Planning
Council of Metropolitan Toronto.

SUBMISSION OF THE SOCIAL PLANNING COUNCIL
OF METROPOLITAN TORONTO.

Appearances: Miss C. Thompson
Miss F.L. Philpott
Mr. W. Kellerman
Miss K. Taggart

MISS PHILPOTT: Mr. Chairman, this
submission this morning was supposed to be in the way
of a verbal statement but we felt it might save your
time and everybody else's if we wrote down what we were
about to say. I would like to introduce the three
people who are with me this morning who assisted the
Board of the Social Planning Council in preparing the
material which is included in this document.

I have with me Miss Thompson, Executive
Director of the Family Service Association of Metropolitan
Toronto; Mr. William Kellerman, Associate Director of
the Catholic Family Services of Metropolitan Toronto and
Miss Kay Taggart, Executive Director of the Visiting
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Philpott

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THE CHAIRMAN: Very well.

MISS PHILPOTT: The Social Planning Council of Metropolitan Toronto appreciates the opportunity to meet with you today and at your invitation to comment on some of the problems faced by the medically indigent with respect to securing health services.

Having followed the meetings of this Commission through the press releases, and knowing of the representations being made to you by other Toronto groups, we have decided to focus our presentation on some broad and important aspects of health care which require special consideration if direct medical services are to achieve maximum results.

Relation of Health and Welfare Services --

Other groups with specialized knowledge of direct health services have made submissions on problems such as out-patient hospital services, home care programs, rehabilitation and co-ordination of hospital and community services. In this connection, the Social Planning Council wishes to emphasize that the new and enlightened philosophy of keeping the physically and mentally ill or handicapped in their own homes or in the community has resulted in increasing demands for services provided by community welfare agencies. It is important, therefore, that it be recognized that many welfare services must be considered as essential parts of the total community health program.

Definition of Medically Indigent -- In

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3 Social Planning Council raised questions as to the
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5 the Council that since much of our existing health and
6 welfare legislation makes specific provision for this
7 group, it is a matter of some importance that the term
8 be defined. The absence of a precise definition makes
9 it difficult to implement legislation and could result
10 in an evasion of responsibility by those responsible
11 for carrying out the legislation. We do urge that the
12 Royal Commission give special attention to this matter.

13 While we do not have statistics to
14 support our position, we are of the view that there is
15 a very large group, far in excess of those in receipt
16 of community welfare services, which would fall within
17 the broadly accepted definition of the "medically indi-
18 gent". We further believe that between the extremes
19 of the seriously poverty-stricken families on the one
20 hand and the well-to-do families on the other, the
21 largest group of medically indigents is to be found.

22 We suggest that this group is composed
23 mainly of fully or partially employed persons or retired
24 persons living on savings. We feel confident that it is
25 this group that most frequently neglects physical and
26 dental care because of limited financial resources.
27 Because of a commendable sense of independence, a resis-
28 tance to dependency, or more frequently a genuine fear
29 of accumulating debts which cannot be met in the fore-
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community. The points that we are emphasizing today refer to this very large group.

We have selected for your consideration five specific general community problems which, in our opinion, produce or aggravate health care problems.

I. HOUSING

Social workers, clergymen, teachers, visiting nurses, visiting homemakers and other human service professions having direct contact with families, can take you to many so-called homes in this area where the housing conditions not only aggravate health problems but perpetuate ill health and indeed in many cases cause health problems. There are numerous families, not only those on public assistance, but those where the breadwinners are employed full time, who occupy dilapidated, rundown, damp sub-standard houses. These houses have poor ventilation, inadequate and dangerous heating facilities, faulty plumbing, disgraceful kitchen and toilet facilities. These houses are to be found not only in the centre of the city, but in what we frequently refer to as semi-rural slums. Overcrowding is a growing problem in some sections of the metropolitan area where large numbers of families share a single house. Other families are housed in large old broken-down buildings where the rents or the payments on the purchase of the house are within reach of the family income. Many of these families are found on the long waiting lists for low cost public housing. There are also a large number of families who "make do" in a couple of rooms, hoping that public housing will soon be available.



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Philpott

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It requires no extensive research by our Council or by any research group to reach the conclusion that overcrowded, unsanitary, poorly equipped, damp and improperly heated accommodation is a direct cause of disease and illness, militates against medical treatment and contributes to the perpetuation and spread of disease and illness.

For example, we know of one family which is typical of many being served by health and welfare agencies. The parents and seven children occupy an old deteriorated four-room bungalow. The house is cold and it is damp. The furnace is in bad repair. Five children sleep in two beds in one small room, one child sleeps with the parents, the seventh child sleeps on a couch in the living room. It is not surprising that the mother has had one serious illness after another such as virus pneumonia, a kidney infection, erysipelas. In addition there have been several minor health problems as well. Nor is it to be wondered at that when the mother came down with the virus infection all seven children contracted the same infection and all remained ill for an unusually long period.

Or, consider the family consisting of three adults and five children living in what can only be described as a three-roomed shack - no basement - water under all the floors - a semi-detached bathroom out of order most of the time - heated by one space heater - no refrigeration and no cupboards - one bed is shared by four children and one adult. As a result of the faulty plumbing, according to a hospital report,

It requires no extensive research by our Council or by any research group to reach the conclusion that overcrowded, unsanitary, poorly equipped, damp and improperly heated accommodation is a direct cause of disease and illness, militates against medical treatment and contributes to the perpetuation and spread of disease and illness.

For example, we know of one family which is typical of many being served by health and welfare agencies. The parents and seven children occupy an old deteriorated four-room bungalow. The house is cold and it is damp. The furnace is in bad repair. Five children sleep in two beds in one small room, one child sleeps with the parents, the seventh child sleeps on a couch in the living room. It is not surprising that the mother has had one serious illness after another such as virus pneumonia, a kidney infection, erysipelas. In addition there have been several minor health problems as well. Now is it to be wondered at that when the mother came down with the virus infection all seven

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the mother developed infectious hepatitis. She returned to this unhealthy, unsanitary, overcrowded shack after receiving hospital treatment. We feel no need to develop any special argument here. The illustration speaks for itself.

Or, a similar situation is that of an immigrant family consisting of two parents and seven children with an eighth child expected soon. These nine people live in three rooms in a dirty dilapidated house. The mother and one child are presently receiving treatment for infectious hepatitis. A third child has recently become ill with an undiagnosed illness. Again, we feel no elaboration on the illustration is necessary.

And one final illustration on housing. This is the case of a deserted wife with four children all under six years of age. They live in two back rooms of an old rundown house. The rooms are small and poorly ventilated. She is in receipt of public assistance and is being served by the Visiting Homemakers' Association to enable her to enter hospital for an investigation of an undiagnosed condition. She is in a highly nervous condition, she has had one illness after another including a kidney infection, and the doctor reports that the children are sick "all the time."

We draw your attention that when the Government, for the protection of children, removes them from their natural parents and places them in either foster homes or institutions, extreme care is exercised to ensure that minimum standards as set forth in statutory regulations are adhered to by foster homes and institutions.



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We have provided no such commendable safeguards either through legislation or the provision of enough low rental housing to assist parents who are capable of taking care of their own children, to provide their children with proper space, equipment and sanitary conditions.

We submit that health costs resulting directly from poor housing are far greater than has ever been calculated. In our view, the health dollar is put to poor use when we treat only the immediate illness but house families in accommodation which causes the illness in the first place, or will certainly be responsible for the spread of illness, not only within the family but probably out to the community.

II. COMMUNITY HEALTH CLINICS

Out-patient clinics should and could provide a most effective health program for our community. The hospital out-patient clinic, or the community health clinic, offers the definite advantage of co-ordinated health services where referral to specialists is facilitated and centralized health records contribute to efficient treatment of the patient.

In Metropolitan Toronto the clinics, as now organized and located, fall short of meeting the community needs. All clinics do not have the same constellation of specialized services, the policies with regard to the charging of fees vary from clinic to clinic, the hours in which clinics are open excludes many persons from making use of them. Many sections of the Metropolitan area are without clinics at all.

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Families and individuals living in these sections must travel long distances for clinical services.

For example, we know of one family of four where the breadwinner suffers from chronic asthma. When working full time he earns \$85.00 a week. Drug prescriptions cost him approximately \$40.00 a month. At present he is paying for private medical care although he would prefer to attend an out-patient clinic. This he cannot do as he cannot afford to lose a day's pay to attend a clinic which is held only in the daytime.

Or, we cite the example of the truck driver earning \$40.00 a week. The family income is supplemented by a teenage daughter who works as a filing clerk and contributes \$15.00 a week to the household. The man has a chronic skin condition and is under treatment from a private doctor because he cannot afford to take time off to attend clinic in the day time. His experience has been that it requires at least three hours at the clinic and considerable travel time to get to the clinic.

Another illustration emphasizes the problem of the location and hours of clinics for mothers of small children. This family consists of a husband and wife and five children ranging in age from two to fourteen. The wife is suffering from acute dermatitis for which she has been hospitalized on two occasions. The family has health insurance which does not fully cover the wife's medical care for dermatitis. She visits clinic about every two weeks and more frequently when there is a flare-up of the skin condition. Attendance

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at clinics poses serious problems for this family.

They live a long distance from the hospital, and each clinic visit requires the greater part of one day.

One of the older children must remain home from school to take care of the younger ones.

If clinics were located more conveniently throughout the area and if evening hours were held, the wage earners and the mothers of small children could take advantage of clinical services without reducing the family income or keeping older children away from school. The loss of a day's pay in order to attend a clinic, frequently results in the low income family reducing the often inadequate food budget.

III. DEBTS DUE TO MEDICAL PRESCRIPTIONS

Drugs, medical appliances, dentures and medical services have caused many low or medium income families to accumulate debts of serious proportions. The new drugs being prescribed we believe are the result of great achievements in medical treatment particularly for many illnesses such as heart conditions, cancer, asthma, pneumonia and so forth. There are many conditions, now treated with drugs, which would have resulted in death just a few years ago. Similarly, there are conditions which previously would have required long periods of hospitalization. These illnesses are now treated at home with the aid of these great new medical discoveries. We can cite numerous examples of families where the debts accumulated in order to fill medical prescriptions have created insurmountable financial difficulties. On the one extreme, we know of many cases



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where the entire family has made financial sacrifices or has deliberately gone into debt in order to ensure necessary medical treatment. On the other hand, there are other cases where the family has decided to withdraw from medical treatment because they can see no way of purchasing the drugs without accumulating debts which they can never pay.

One example typical of many others is the young family consisting of the parents and three children. They have proved themselves to be resourceful and have a healthy feeling of self-dependence. They are buying a large old house. They have a home improvement loan. They are a hard-working, conscientious little family.

This family has required Homemaker Services on three occasions, due to the illness and hospitalization of the mother. The mother's hospital costs are covered by a medical plan to which they belong, but the younger child who has a very serious bowel condition is not fully covered by the plan. The child's condition is considered chronic. This family is paying approximately \$85.00 a month to cover the cost of drugs, special diets and vitamins for the baby. None of this is covered by the medical plan. The family has already taken out one bank loan to cover medical expenses. With the increased medical costs confronting them, the possibility of paying off their steadily mounting debts seems remote.

Another typical example is found in an immigrant family. The father in this case borrowed

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heavily to move his family and relatives to Canada. The family has been most reluctant to seek assistance from any community agency. By January 1960, the family was in debt to the amount of \$1,400.00. The family occupies low cost housing, the children have after school jobs, the children are doing well in school and the relationships in this family are close and strong. Both the husband and wife urtently require medical attention. The wife is presently refusing to see her doctor because she fears separation from her children in order to receive treatment and recognizes that this could add to the family's financial stress.

The husband, since coming to Canada, has had an outstanding work record, advancing steadily from an unskilled job to a semi-skilled job. His health has been rapidly deteriorating over the past few months and he is presently missing considerable time from work. Clinical tests in one four-week period cost him \$35.00. In view of his already heavy debts he has decided to discontinue his medical care although he has been advised that he suffers from high blood pressure, a kidney and liver condition and requires extensive dental care. The strengths in this family are many. The parents are concerned for each other and for their children. The decision of this family to forego medical care rather than to accumulate additional debts is obviously not the right solution for them or the community.

IV. VARIATIONS IN MEDICAL SERVICES DETERMINED BY MUNICIPAL BOUNDARIES

Within the Metropolitan area, we still



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IV. EVALUATION IN MEDICAL SERVICES DETERMINED BY
MUNICIPAL BOARD



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have the problem of variations in medical care provided in the different municipalities. This raises the question about the present administrative units responsible for health and welfare programs.

For example, Mr. "A" was self-employed until July 1960 when he suffered a serious physical disability preventing him from carrying on with the heavy manual employment in which he was engaged. He then became eligible for public assistance. He was under the care of a hospital clinic. Long-term drug therapy was prescribed requiring an expenditure of \$12.00 a month for which the City of Toronto Department of Public Welfare assumed responsibility. In July 1961 the family moved into another municipality within the Metropolitan area. This municipality continued public assistance but refused to provide drugs on the basis that the condition is chronic and will be a continuing health problem. As a result of the foregoing decision which has been reconfirmed, Mr. A. has given up his drug therapy, a situation which in our opinion is grave. Had Mr. A. not moved to another municipality this crisis would not have arisen.

V. EDUCATION OR HEALTH CARE

How can a family choose between food or education for teenage children, or dental and medical care? All are essential both for mental and physical health. These choices, however, must be made by families who are receiving certain types of government allowances with children over sixteen years of age. At a time when we are all convinced of the importance of



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keeping children in school to finish their training so that they do not become a part of a great army of unemployed, unskilled, transient and homeless twenty years from now, it is our view that the Royal Commission should give special attention to the health needs of teenagers.

For example, there is the case of a fifty-eight year old widow with a seventeen-year old adopted son. The mother who has limited vision receives a \$65.00 a month disabled persons' allowance, plus a mother's allowance of \$30.00 a month. The mother, because of a variety of physical disabilities attends hospital clinics regularly. Because of her limited sight, the son must remain away from school to help her get to clinic. The son is taking a trade course and the mother, quite rightly, is determined that he will complete his training. Since he reached his sixteenth birthday, they no longer receive family allowance. The boy has now been examined at dental clinic and has been told that he requires extensive dental care at an estimated cost of \$145.00. Dental care is not extended under the Mother's Allowance Act after a child has reached sixteen years of age. In view of the definite relationship between dental and physical health, the neglect of dental care for children being supported under governmental allowances will probably result in adding to Canada's future health problems.

In conclusion, it is our sincere hope, Mr. Chairman, that this Commission will make specific recommendations about: out-patient clinics, the provision

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THE CHAIRMAN: Thank you very much Miss Philpott. Having reduced to writing what you would have said has been very helpful and I think it also perhaps points out the sympathetic approach which these problems are dealt with by the Social Planning Council here in Toronto.

In this matter of clinics have you found any real reason why there cannot be some night clinics to begin with?

MISS PHILPOTT: I wonder if any other members who work most directly with the hospitals have any information on this.

MISS TAGGART: I am afraid I cannot answer that, no. I don't know why they do not exist.

THE CHAIRMAN: They just do not exist. Do you know of any reason? Have there been suggested any real reasons why they might not exist?

COMMISSIONER GIRARD: I just wanted to ask in relation with this: Are not the hospital emergency clinics open all night and every night where anyone can always go if there is some real trouble?

MISS PHILPOTT: Yes. I think Mr. Chairman our main concern, however, is in relation to people with chronic conditions where I don't think we could expect the private physician to continue giving care over an extended period of time when he can do it more effectively in the clinic and the family know it is not for a couple or a few days but is going on for years. The clinic offers the best and most effective way of treating not only his medical care but prescriptions.



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4 THE CHAIRMAN: That would not be
5 regarded, I take it, as an emergency entitling a patient
6 to go to the emergency clinic?

7 MISS PHILPOTT: No.

8 THE CHAIRMAN: That is something which
9 might well require some serious consideration in terms
10 of providing the service. You have given here the
11 various cases that you intended to deal with in answer
12 to my letter of March 12th.

13 MISS PHILPOTT: Yes.

14 THE CHAIRMAN: And you have taken these,
15 I take it, as typical?

16 MISS PHILPOTT: Mr. Chairman, it was
17 the decision of the Social Planning Council that we
18 would not bring forward to this Commission very unusual
19 or a typical example of which we had many of very
20 outstanding problems of health care. We decided that
21 we would bring before you today only examples of cases
22 where they seem to represent a very general problem in
23 the community.

24 THE CHAIRMAN: That is what we wanted.
25 You have appeared in response to our direct invitation
26 in this regard.

27 MISS PHILPOTT: That is correct.

28 THE CHAIRMAN: We wanted to know just
29 what the situation actually is at the level at which
30 your Department operates in Toronto and we have had
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6 is to come here with actual situations typifying the
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9 I don't know that there is much else
10 that we can add to it except to tell you how grateful
11 we are that you did accept our invitation and for the
12 information you have given us and I think you may be
13 assured that it is information that we will have very
14 much in mind when we come to formulate policies and
15 proposals.

16 Now if there is anything else that
17 you might wish to add ---? I don't want to cut off the
18 discussion, or any other members have instances or
19 illustrations you might want to give us. Mr. Kellerman
20 or Miss Taggart?

21 MISS TAGGART: Just one comment I
22 would like to make in regard to the typical nature of
23 the examples. I think some of them might appear to be
24 less typical than they are because the particular
25 medical diagnosis may be unusual but it represents the
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27 you know, in one condition might not be very prevalent
28 but conditions requiring drugs are prevalent. Do you
29 see?

30 THE CHAIRMAN: Yes. Now you see our
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3 within the scope of your Department.

4 COMMISSIONER GIRARD: Mr. Chairman,
5 I would like to make a comment at this point. Having
6 done public health nursing about 20 years ago these
7 examples are very typical of what I found at that time
8 so we don't seem to make too much progress, do we? I
9 recognize every one of these examples being some of the
10 things that I had found in homes when I was visiting
11 in the homes and they still exist so I suppose that
12 that points up the need to really try to do something
13 about them.

14 THE CHAIRMAN: This is reaching to the
15 root.

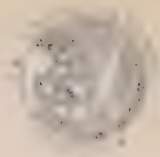
16 MISS PHILPOTT: Mr. Chairman, the
17 Commission may be interested to know that the housing
18 authorities within the Metropolitan area estimate that
19 our requirements to provide sufficient housing for our
20 people in this community would require new low cost
21 housing units, the figure varies anywhere from 30,000
22 to 40,000 is required within the Metropolitan area.

23 THE CHAIRMAN: Units?

24 MISS PHILPOTT: Yes.

25 COMMISSIONER STRACHAN: Mr. Chairman,
26 may I make a comment regarding the last page mentioned.
27 The seventeen year old boy who now requires dental
28 attention to the extent of \$145.00. I wonder if he
29 availed himself of the dental attention he could have
30 received up to 16 years of age?

I find it difficult to understand how
he could accumulate that amount of work in such a short



within the scope of your Department.

I would like to make a comment at this point. Having

done public health nursing about 20 years ago these

examples are very typical of what I found at that time

so we don't seem to make too much progress, do we? I

recognize every one of these examples being some of the

things that I had found in homes when I was visiting

in the homes and they still exist so I suppose that

that points up the need to really try to do something

about them.

THE CHAIRMAN: This is reaching to the

root.

MISS PHILPOTT: Mr. Chairman, the

Commission may be interested to know that the housing

authorities within the Metropolitan area estimate that

our requirements to provide sufficient housing for our

people in this community would require new low cost

housing units, the figure varies anywhere from 30,000

to 40,000 is required within the Metropolitan area.

THE CHAIRMAN: Units?

MISS PHILPOTT: Yes.

may I make a comment regarding the last page mentioned.

The seventeen year old boy who now requires dental

attention to the extent of \$145.00. I wonder if he

availed himself of the dental attention he could have

received up to 16 years of age?

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Philpott

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4 period of time if he had received the attention he could
5 have received up to the age of 16.

6 MISS THOMPSON: I think it is undoubtedly
7 true that attention had not been given. I am not,
8 however, sure that I could give every reason why that
9 attention was not given except that we do find, not only
10 in our family counselling work but in camp programs and
11 so on, a terrific neglect of dental health. This would
12 be an example.

13 COMMISSIONER STRACHAN: I would like
14 to point out, Mr. Chairman, that this is a case where
15 it was available. I would presume, as Dr. Dunn suggested
16 to us the other day, it is not being used to the degree it
17 is available. We have no proof of that in this case.

18 MISS PHILPOTT: That is correct. I
19 think we should say here for the record that we have
20 checked the official policy of the Mother's Allowance
21 which is the plan under which this family is, and up
22 until the age of 16 the children do get dental care as
23 well as medical care. It is after they reach the age
24 of 16, between 16 and 18 where they could still receive
25 Mother's Allowance.

26 COMMISSIONER STRACHAN: But many who
27 could receive it up to 16 do not request it.

28 MISS THOMPSON: This is your point:
29 Up to 16 the opportunities, if they were there, were
30 not used.

COMMISSIONER STRACHAN: Right.

MR. THOMPSON: Which is true, and I
suppose makes us realize there is a relationship here to

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Philpott

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the guidance that the children get in their families,
and so on, that we cannot separate off from the use of
community resources.

THE CHAIRMAN: Thanks very much again
Miss Philpott and Mr. Kellerman, Miss Taggart, Miss
Thompson. We are very grateful to you for this help.

MISS PHILPOTT: Thank you very much.
We are very glad for your invitation to come.

THE SECRETARY: The next submission,
Mr. Chairman, is from the Department of Public Health of
the City of Toronto, Pilot Home Care Program, which will
be known as exhibit 358 and the three annual reports
attached thereto will be known as 358A. Miss Sharpe
will speak to this brief and introduce the members of
her delegation.

---EXHIBIT NO. 358:

Submission of the Department
of Public Health of the
City of Toronto, Pilot Home
Care Program.

---EXHIBIT NO. 358A:

Three annual reports of the
Department of Public Health
of the City of Toronto,
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Philpott

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Submission of the Department
of Public Health of the
City of Toronto, Pilot Home

---EXHIBIT NO. 358:

Three annual reports of the
Department of Public Health
of the City of Toronto,

---EXHIBIT NO. 358A:



SUBMISSION OF
THE ADVISORY COMMITTEE, PILOT HOME CARE PROGRAM, DEPARTMENT
OF PUBLIC HEALTH
CITY OF TORONTO

APPEARANCES:

MISS G. SHARPE,
MRS. J. BARTER,
DR. L. A. PEQUEGNAT.

MISS SHARPE: Mr. Chairman, this submission to the Royal Commission is on behalf of the Advisory Committee to the Pilot Home Care Program of the City of Toronto. Those who are appearing this morning, I will introduce them. To my right is Mrs. Barter, the Administrative Assistant of the Toronto Pilot Home Care Program, and Dr. Paquengnat, the Medical Administrator of the Toronto Pilot Home Care Program.

If it is your wish, may I read the Foreword, and following that the summary and recommendations?

THE CHAIRMAN: Yes, please.

MISS SHARPE: The contained submission has been prepared at the behest of an Advisory Committee to the Medical Officer of Health made up of representatives of the several community services and disciplines involved in a Pilot Home Care Program given for administration and overall operation to the Department of Public Health of the Area Municipality of the City of Toronto. The aegis it enjoys is not of necessity the only one appropriate to a program of the kind but is rather one, a suitable one,



UNITED KINGDOM CARE PROGRAM

CITY OF TORONTO

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Sharpe 12159

emerging from certain factors which seemed to govern at time of contemplated creation of a service at the local level, principal among the factors being the one of procurement of adequate funds with federal health grants-in-aid constituting a possible source. Such funds were realized four years ago and since that time have furnished the life-blood for an extremely interesting and fruitful pilot program of study and research.

To conform to an expressed wish of the Royal Commission a summary is offered of the text which follows hereafter.

1. Home care is defined as an organized effort and is represented to be an integral part of the Medical Care concept. It must have appropriate, perhaps official recognition and stimulus if it would serve optimal purpose, or, in other words, if it would serve to integrate the various services which go into it, assess and evaluate these and reach the appointed goals with the maximum of despatch.

2. As implied, Home Care amounts to medical and related care in a home setting. It is not in competition with care in hospital but may at times, or in stages of illness, take over. An economy is apparent.

3. The text next presumes to set out the circumstances which give base - denote the state of readiness in other words - if one would innovate local program capable of enjoying the potentials inherent in such.

4. Types of program are next dealt with, possibilities being the hospital-based, the community-

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Sharpe 12160

based, certain variants or a blend of the two. Comparative values are briefly reviewed.

5. The Toronto experiment, a pilot program, follows in discussion, community-basing having been chosen as the type of choice. With limitations to date noted, certain evidence of success is adduced. Likewise the problems of program as already revealed are cited.

Program which for a number of years has accepted any reliable source as a suitable point of origin for a case, the hospital as one, has recently added an extension which on selective basis, will take patients out of hospital earlier than would normally be the case and continue and complete their care in the home on a contract to defray cost as though continuing in hospital under prepaid hospitalization benefits. Interest having turned in this direction as a part of hospitalization economy the newer study is leading the way in Ontario to the provision of direct evidence related to the question under review.

6. The future of financing of home care in both of its phases, the exploratory and that of permanent installation, the latter the more imminently pressing, is discussed to the extent possible within the present state of affairs.

7. The brief also has proposals and recommendations which it would offer respectfully in the hope that they may further comment and discussion and perchance recommendation at the hands of the Commission. This particular material by direction is placed immediately next to this summarization.

The recommendations.

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Sharpe 12161

With full regard to the incompleteness of findings on Organized Home Care, having nonetheless formed and offered some quite firm opinion on the matter, one may reasonably expect, it would seem some comment, even recommendation, from the Commission.

The facts seemingly established are these:

1. That there is keen interest everywhere in home care properly applied.
2. That through demonstration, here and there, interest has become a conviction of need and that in properly organized and sizeable territory an adequate case load will develop quickly.
3. That pilot programs, customarily limited in area for coverage, soon reveal the need for wider application. Toronto's case is one in point.
4. That with full respect for Federal grants-in-aid some pattern of permanent financing must be evolved, the aegis under which program shall proceed being more a matter of determination at the local level.

The following proposals are respectfully submitted.

1. That the Commission record its acceptance of Organized Home Care as an integral component of the Medical Care concept.
2. That the Commission presume to inspire the appropriate authorities and organized



Sharpe 12162

entities, be these at the local, provincial or national level, official or voluntary, as to the need for fuller exploration of the field of home care in its relation to the health services economy; that, in particular, with economy and patient interest both in mind, hospital services commissions and like bodies across Canada be encouraged to explore home care as an alternative to be honoured in selected circumstances to in-hospital care under membership contract; that to the extent necessary there continue to be release of public funds to provide for these explorations; that there be enjoined at these levels the taking of action in accordance with the findings.

3. That special emphasis be put by the Commission on the growing imminence of need to find the best formula which will meet the financial requirements of the permanent program, a task reasonably assignable in its early stage at any rate, to the provincial government in that it already is in the broad area of hospitalization, institutionalization, rehabilitation and much of related purpose.

THE CHAIRMAN: Thank you very much, Miss Sharpe. We are much in your debt for this brief and for your attendance here. We have heard in many parts of Canada of the fact that a home care program might well be very valuable in two aspects. One from the standpoint of

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Sharpe 12163

the patient, and the second in the monetary aspect of saving patient-days in the acute general hospital, and the subject is extremely topical. It is relevant to our inquiry, and as I say, we are indebted to you for this presentation.

Miss Girard is going to expand the matter. She is much more knowledgeable in this field than the rest of us.

COMMISSIONER GIRARD: Thank you, Mr. Chairman. Miss Sharpe, as the Chairman said, we were looking forward to someone who could give us a lot more information on home care, since about at least 50% of the briefs mentioned it, and very few of them had any tangible experience in home care.

As you have mentioned, there are different varieties of home care plans, and yours here in Toronto is a community-based plan, which is self-explanatory, of course.

On your summary, Page 2, there is one paragraph there that I think we could probably elaborate: "A program which for a number of years has accepted any reliable source as a suitable point of origin for a case, the hospital as one, has recently added an extension which on selective basis, will take patients out of hospital earlier than would normally be the case and continue and complete their care in the home on a contract basis." This means that at the beginning you started by taking cases, any cases that would be referred from any sources?

DR. PEQUEGNAT: Any reliable sources, yes, the workers on the case, hospitals included. Even



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Pequegnat 12164

families might inquire. In other words, inquiries led to a screening, and then referral, or the referral had to come from the family's physician, the final referral.

COMMISSIONER GIRARD: So if a family in need contacted you, you would ask them to get their family physician to get in touch with you?

DR. PEQUEGNAT: Yes, we might even presume to get in touch with the family physician.

COMMISSIONER GIRARD: And from there on you would carry on with the family physician as the supervisor of the care?

DR. PEQUEGNAT: He writes the total prescription for care, the total prescription.

COMMISSIONER GIRARD: In the latter part of this paragraph you say you have extended to a certain extent this method. Would you care to give us more information on that?

DR. PEQUEGNAT: Yes, as a matter of fact, I was hoping to be able to write in an addition to Paragraph 12, in which we set out what we failed to set out, that in the extension program the home servicing fully represents that of a standard in basic treatment, other than the patient is relieved of all costs other than the medical attending fee. While the Hospitalization Commission has not yet assumed the cost of this care, the pattern nonetheless is there.

We have a budget which was otherwise procured for that purpose, but the patient is being continued on home care as though he were continually in hospital, and the cases of the type which the doctors in



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Pequegnat 12165

the hospital will certify that if it were not for our program they would have had to continue in hospital.

There are programs in the United States. I have some very interesting figures on what the costs have been of the programs, and what the hospital savings might be valued at, and what the ratio is between costs at home and continuing in hospital.

THE CHAIRMAN: If we could be provided with those figures they would be valuable information.

DR. PEQUEGNAT: Well, as a matter of fact, I have some right here.

THE CHAIRMAN: If we can have them in manuscript form to the Secretary, they will go directly to our research people.

DR. PEQUEGNAT: As this addendum here says, costs are met from a program treasury in the standard program. On the other hand, the recipients of the service pay what they can towards the going rates. In other words, the hospitalization people are not paying for it, but we still take only those who have hospitalization contracts for purposes of comparison and avoiding certain technical difficulties.

MISS SHARPE: It is the latter part of Dr. Pequegnat's explanation that answers Miss Girard.

COMMISSIONER GIRARD: Since you are on the subject of costs, I picked up in the Appendix, the Third Annual Report, some figures. The income from family in your program has been 48% in 1959 and 31% in 1961. Have you any idea why this seems to be going down?

DR. PEQUEGNAT: There was one case that

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DR. PEDERSEN: There was one case that



Pequegnat 12166

brought about that big change. I am not saying it produced the whole of the difference, but there was one case that had the type of insurance which paid in a very large sum, and so raised the percentage which was paid for.

THE CHAIRMAN: In 1959?

DR. PEQUEGNAT: Yes, that is an anomaly, as a matter of fact, sir.



1953

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THE CHAIRMAN: In 1953?

DR. FLETCHER: Yes, that is an anomaly

as a matter of fact, sir.



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COMMISSIONER GIRARD: Now, we often hear of the number or the different categories of personnel that are needed in implementing a homemaker program, and I noted here the number of patients taken care of, I think it is in 1961: Nursing at 109, homemakers 70%, physio-occupational therapy 46, and social service 17. I did not notice anywhere that you had called for the services of a dietitian, and I was thinking all along that dietitians were a necessary part of a health care program. Would you tell me why?

MRS. BARTER: Mr. Chairman, it is interesting that we have on two occasions only in three years requested nutritionist services directly, person to person, for a patient. The visiting nursing agencies and the public health agencies have access to nutritionist consultation, and we have apparently found that the nurse has been able to guide the patient with their nutrition needs except in two instances where we made this request and provided nutritionist services.

COMMISSIONER GIRARD: This should make them feel good, they are doing a good job in educating nurses in nutrition, and this is, of course, what I think after nursing it is the homemakers that are in greatest demand, having been required in 70 cases in relation to 109 cases where nurses were needed.

I don't think there is any question I can ask, except to make the comment that has been made so often, that we need homemakers' services.

MRS. BARTER: I think that once again there is an opportunity to record need and amounts

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3 because the services is available; when no service is
4 available it is possible to do no more than state the
5 fact that they are needed, and here almost for the
6 first time it is possible to provide not only family
7 service, which is more generally available, but also
8 services to adults without families, to older people,
9 to help them and maintain them in the community, and we
10 see a very decided need for homemaker help in these
11 categories of patients and I think we are able to document
12 it for the first time as requiring anywhere from three
13 hours a week up to 100 hours a week.

14 COMMISSIONER GIRARD: This brings me
15 to another question. I read somewhere in here that you
16 could not get homemaker services from the agencies for
17 less than four hours a day. When you have cases where
18 you need one for only two hours you have to rely entirely
19 on family services? What do you do when you need one
20 for less than four hours?

21 DR. PEQUEGNAT: We have employees of
22 our own on that basis. Mrs. Barter will enlarge on that.

23 MRS. BARTER: Commercial agencies
24 will not provide homemaker service on less than a four-
25 hour basis. We were fortunate enough in our first
26 two years of demonstration to have the services of part-
27 time homemakers' service for a pilot project that was
28 being carried on by the Homemakers' Association. This
29 service was available for as little as an hour at a time.
30 When this pilot project finished we took on some of the
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Barter

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for as little as an hour and they go from patient to patient during the same day.

COMMISSIONER GIRARD: But this is something that you happened to have; it is not an established fact?

MISS SHARPE: No.

COMMISSIONER GIRARD: You have it now because you are running this pilot project?

MISS SHARPE: That is right.

COMMISSIONER GIRARD: In other words, there has been nothing done to find the homemaker they could use for a couple of hours. Would you say that it is one of the needs of these agencies, to be able to fill that need?

MRS. BARTER: Well, it is a need. I don't know who is going to be able to provide it. But to overserve on a rehabilitation program makes it very difficult for the patient to be as fully independent as we hope for them, and also makes it difficult for homemakers to sit down and do nothing.

COMMISSIONER GIRARD: There is one question. I can't recall again where I saw it. We did say this was a community-based program and most of the cases are under the supervision of the family doctor. I did see that about 9% of the cases were under the supervision of a clinic. Is that correct?

MISS SHARPE: Yes, that is correct.

COMMISSIONER GIRARD: Those cases have been referred to you by the hospital?

DR. PEQUEGNAT: By the hospital



for as little as an hour and they go from patient to patient during the same day.

COMMISSIONER GIBBARD: But this is

something that you happened to have; it is not an established fact?

COMMISSIONER GIBBARD: You have it now

because you are running this pilot project?

MISS SHARPE: That is right.

COMMISSIONER GIBBARD: In other words,

there has been nothing done to find the homemakers they could use for a couple of hours. Would you say that it is one of the needs of these agencies, to be able to fill that need?

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COMMISSIONER GIBBARD: There is one

question. I can't recall again where I saw it. We

did say this was a community-based program and most of the cases are under the supervision of the family doctor. I did see that about 8% of the cases were under the supervision of a clinic. Is that correct?

MISS SHARPE: Yes, that is correct.

COMMISSIONER GIBBARD: These cases

have been referred to you by the hospital?

MISS SHARPE: By the hospital.



Barter

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4 clinician. In other words, the clinician at the hospital
5 becomes the private physician to that patient in cases
6 that travel back and forth to and from the hospital
7 without danger to their condition. Theoretically the
8 home care case should be home-bound, but the home care
9 case can reach outdoors even if he has to be transported.

10 COMMISSIONER GIRARD: On page 4 of
11 your recommendations it says:

12 "That the Commission presume to
13 "inspire the appropriate authorities
14 "and organized entities, be these at
15 "the local, provincial or national
16 "level, official or voluntary, as to
17 "the need for fuller exploration of the
18 "field of home care in its relation to
19 "the health services economy; that,
20 "in particular, with economy and patient
21 "interest both in mind, hospital services
22 "commissions and like bodies across
23 "Canada be encouraged to explore home
24 "care as an alternative to be honoured
25 "in selected circumstance to in-hospital
26 "care under membership contract."

27 Would you like to elaborate on that,
28 this last part of the paragraph?

29 DR. PEQUEGNAT: This refers again to this
30 extension program, to take patients out of the hospital
earlier. In other words, there is a portion of the latter
days of hospital care in the home by virtue of being able
to transfer into the home a hospital care, a hospital type

clinician. In other words, the clinician at the hospital becomes the private physician to that patient in cases that travel back and forth to and from the hospital without danger to their condition. Theoretically the home care case should be home-bound, but the home care case can reach outdoors even if he has to be transported.

Your recommendations it says:

"That the Commission presume to
"inspire the appropriate authorities
"and organized entities, as there are
"the local, provincial or national
"level, official or voluntary, as to
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Pequegnat

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4 of care, equivalent to hospital care. That is what is
5 referred to here.

6 COMMISSIONER GIRARD: Is this the
7 one you said you would give us some figures on?

8 DR. PEQUEGNAT: Yes.

9 COMMISSIONER GIRARD: Have you any
10 figures on what it would cost in the hospital as opposed
11 to the home, the economy?

12 DR. PEQUEGNAT: In the United States
13 they had 300 cases, 67.24%, estimated hospital days
14 saved, estimated by physicians, and that is borne out
15 by actual reaffirmation, they were asked to give an
16 estimate and then again asked to review their estimate
17 after the patient has been discharged, was that it was
18 20 days, and the cost of the home care was under \$4.00
19 a day. If we take it at \$700.00, that gives us a figure
20 of \$260.00 as pertaining to that one city in particular,
21 and the hospital day is \$35.00. So there is a ratio
22 there of one to three.

23 We have taken other cases; perhaps it
24 is a little early to tell you with any definiteness about
25 these cases, but we seem to have a saving which again
26 bears pretty much the same ratio of one to three. In
27 other words, the home care program, it is still only a
28 matter of a third of what the hospital day is valued at.
29 Of course, what one has to caution against is that saying
30 you have saved hospital costs is a relative statement.

THE CHAIRMAN: You don't save hospital
costs, you just empty the beds for another person to get
into it?

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THE CHAIRMAN: You don't save hospital

costs, you just empty the beds for another person to pay



Pequegnat

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DR. PEQUEGNAT: Yes. In other words, it denotes a more economic use of the hospital bed.

COMMISSIONER GIRARD: This program has been financed so far through grants in aid.

DR. PEQUEGNAT: Yes.

COMMISSIONER GIRARD: Who do you suggest should pick up this when the pilot project finishes?

THE CHAIRMAN: Have you given consideration to the fact that it should be done under the hospitalization plan, divided equally between the province and the dominion?

DR. PEQUEGNAT: That portion which has hospitalization connotation, one might have to think in terms of a local organization, and the sponsorship or auspices of that local organization can vary. Let's assume that the health authority might continue and enlarge it. We have now only about a quarter of the city covered, and then we cover another quarter and then we come to the core municipality, and we have no unified health authority at the present time.

THE CHAIRMAN: But you have the hospital commission which operates for the whole province?

DR. PEQUEGNAT: Yes. I would say sooner or later the hospitalization commission will come in with this interest in respect of those people who have the hospitalization connotation or corollary.

And then we have got the question, too, that the liberalization and amendment of some of the sharing legislation which rests at the provincial level, for instance, the Homemakers and Visiting Nurses Act,



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for instance, the Homekeepers and Visiting Nurses Act,



Pequegnat

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3 and then we have got this new rehabilitation legislation
4 which is being announced at the present time. Because,
5 after all, the first act takes care of only homemaking
6 and nursing. We have also physiotherapy, and so on,
7 several other items of home care. You have the
8 possibility of setting it up at the local level with the
9 sharing, preferably, from the province through acts
10 of this kind, and then you have the hospitalization
11 commission entering in respect of patients who need care
12 which otherwise have it provided for in the hospital.

13 Then, of course, we are looking forward
14 to the day we can have a master health services plan in
15 which we want home care to be recognized to the degree
16 that it should.

17 THE CHAIRMAN: Thank you very much,
18 Miss Sharpe, Mrs. Barter and Dr. Pequegnat. As I said,
19 we were anxious to hear from you, and the information you
20 have given us is going to be very valuable. We would
21 also appreciate having those figures, those statistics
22 you think you will be able to give us from the American
23 experience.

24 MISS SHARPE: May we ask when you would
25 like to have those figures?

26 THE CHAIRMAN: Reasonably soon, whenever
27 they are available, within the next two or three months.
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THE CHAIRMAN: Thank you very much, Miss Sharpe, Mrs. Barber and Dr. Laguerre. As I said, we were anxious to hear from you, and the information you have given us is going to be very valuable. We would also appreciate having those figures, those statistics you think you will be able to give us from the American

MISS SHARPE: May we ask when you would like to have those figures? THE CHAIRMAN: Reasonably soon, wherever they are available, within the next two or three months.



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THE SECRETARY: Mr. Chairman, the next brief is that of the Planned Parenthood Association which will be Exhibit No. 359.

--- EXHIBIT NO. 359: Submission of the Planned Parenthood Association.

SUBMISSION OF THE PLANNED PARENTHOOD ASSOCIATION

Appearances: Prof. L.C. Walmsley
Dr. F.D. Fidler
Mr. I. Bain
Dr. D.J. Dodds

THE CHAIRMAN: Yes, Professor Walmsley?

PROF. WALMSLEY: Mr. Chairman and members of the Commission: the members of this Committee are Dr. Fidler, who is Chairman of the Committee of Christian Family Life of the United Church of Canada; Mr. I. Bain, who is a social worker in the City of Toronto and Dr. Dodds, who is a physician in Toronto. My own position is on the staff of the University of Toronto.

We represent the Planned Parenthood Association which is an organization in the process of being formed similar to that which has been formed in over 30 other nations of the world. The summary of the brief which we are presenting is as follows:

The Planned Parenthood Association believes:

1. That every child's birthright includes: the right to love and care of parents who welcome his arrival; a secure place in a whole family; living conditions which are conducive to decent upbringing in clean, healthful surroundings; moral instruction;

THE SECRETARY, Mr. Chairman, the next

brief is that of the Planned Parenthood Association
which will be Exhibit No. 300.

--- EXHIBIT NO. 300: Submission of the Planned Parenthood Association.

SUBMISSION OF THE PLANNED PARENTHOOD ASSOCIATION

Dr. F. J. Fidler
Mr. I. Barn
Dr. D. D. Bodda

THE CHAIRMAN: Yes, Professor Wainwright?

PROF. WAINWRIGHT: No, Mr. Chairman and

members of the Commission: the members of this Committee
are Dr. Fidler, who is Chairman of the Committee of
Christian Family Life of the United Church of Canada,
Mr. I. Barn, who is a social worker in the City of
Toronto and Dr. Bodda, who is a physician in Toronto.
My own position is on the staff of the University of
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includes the right to love and care of parents who

welcome his arrival; a secure place in a whole family;

living conditions which are conducive to decent upbringing

in clean, healthful surroundings; moral instruction;



Walmsley

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education in keeping with his abilities; the opportunity for spiritual growth; and guidance toward maturity and the responsibilities of adult life.

2. That many of these precious assets are denied the child whose arrival is unplanned and unwelcomed.

3. That parents are entitled to freedom of choice about the number of children they should have, and when they should have them.

4. That there should be no legal barrier to the free dissemination of information about contraception, or to the manufacture, sale or distribution of ethical contraceptives.

The Planned Parenthood Association recommends:

1. That the enquiries and studies conducted by the Royal Commission on Health Services give due consideration to the place of contraception services among the other personal health needs of the Canadian people.

2. That consideration be given to the need for dissemination of information about contraception in hospitals, clinics, and through public health units and departments.

3. That, as a necessary first step, this Royal Commission recommend to the Government that Section 150 of the Criminal Code, which this Association believes to be an iniquitous and discriminatory invasion of the privacy of Canadian citizens, be amended and any reference to contraception eliminated.

THE CHAIRMAN: Thank you, Professor



education in keeping with his abilities; the opportunity for spiritual growth, and guidance toward maturity and the responsibilities of adult life.

2. That many of these precious assets are denied the child whose survival is unplanned and unplanned.

3. That parents are entitled to freedom of choice about the manner in which their children should have, and when they should have them.

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The National Parenthood Association Recommendations

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Walmsley

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Walmsley. You have documented your submission with many quotations from medical people, etc., and the question of planned parenthood is, as you appreciate, a controversial one. However, merely because it is controversial does not make the presentation any less relevant. Is there anything further you want to add by way of comment?

PROF. WALMSLEY: Although it is a controversial topic we do believe there should be freedom possessed by the citizens of Canada for information; those who wish to have it withheld for their own special purposes may have it so but we do believe it should be available for those who are in need of it and who desire it.

COMMISSIONER VAN WART: Just one thing to clarify the record regarding the Criminal Code section; it is only the words "method of preventing conception" that you want stricken out of the Criminal Code, it is not the other two conditions mentioned in the Code?

PROF. WALMSLEY: Yes, that is the primary part that we believe should be eliminated.

COMMISSIONER BALTZAN: Gentlemen, I am glad you brought this matter up for some of us who have not been alerted to the upsurge of it here. You speak of preventive methods, contraception; does your organization go further and consider even going to the point of sterilization in order to obtain objectives in certain given instances?

PROF. WALMSLEY: We have not considered that primarily.

Wainwright. You have connected your administration with

question of planned parenthood as, as you appreciate,
a controversial one. However, merely because it is

relevant. Is there anything further you want to add
by way of comment?

PROF. WAINWRIGHT: Although it is a

controversial topic we do believe there should be
freedom possessed by the citizens of Canada for informa-
tion; those who wish to have it should be free to
special purposes may have it so that it is to be made
should be available for those who are in need of it and

COMMISSIONER: All right, that was the

to clarify the record regarding the original G.C. decision;
it is only the words "method of having the connection"
that you want stricken out of the original G.C. it is
not the other two conditions mentioned in the G.C.?

PROF. WAINWRIGHT: Yes, that is the

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have not been alerted to the question of it here. You
speak of preventive methods, contraceptive, does your
organization go further and consider even going to the
point of sterilization in order to control fertility
in certain given instances?

PROF. WAINWRIGHT: We have not considered

that primarily.



Walmsley

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COMMISSIONER BALTZAN: That is fine, thank you. One other point, and that is this: judging by physicians' reports, time and again over a long period of time, there seems to be more often the question for information about infertility and remedies for infertility than methods for control measures. This is sort of a paradoxical thing but on page 2, No. 6, you do certainly support every and any kind of aid for these people to be considered.

PROF. WALMSLEY: Yes.

COMMISSIONER BALTZAN: I mention this only because physicians have tended to press people with the other, which is sort of paradoxical, that there is a greater demand for information by an anxious parent who is childless rather than the questions for control.

DR. DODDS: I would not agree with this. I would think that unless there is a religious barrier that every woman who has a child, she has to have information about how she can control her family. Every one of my patients who has a child I make sure I open up the subject and they are all interested unless there is some religious barrier.

People who have difficulty having children are comparatively rare so the vast number of questions come about controlling families, contraception, rather than the difficulties of becoming a parent.

COMMISSIONER BALTZAN: Of course, there is an individual variation between doctors. I consider your point that this is the other half of the aspect of the question of infertility and demands for improvement

COMMISSIONER BARTON: That is fine.

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COMMISSIONER BARTON: Of course, there is an individual variation between doctors. I consider you point that this is the other side of the aspect of the question of infertility and demands for improvement



Walmsley

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and remedy for infertility.

PROF. WALMSLEY: The problem of infertility and the inability to have children is also one of the major interests of the Planned Parenthood Association. This is one of the fields in which we are concerned as well as the prevention and proper spacing of children.

THE CHAIRMAN: As one reads the submission, I suppose what is called the population explosion becomes one of the grounds upon which you support the submission. Is there any evidence of that in Canada or is that affecting the situation in Canada? After all, we are concerned with the Canadian scene here.

DR. DODDS: There was an article recently published in Look Magazine, I think, with respect to the United States where conditions are very similar to ours. As it states in part of the brief here, it appears that various services in community planning and so on, the article in Look, some time early this year or late last year, points out the problems of water supply, social services and many other things. It is very well-documented there.

THE CHAIRMAN: And in terms of Canada we appear to hear that the need is for more population, not for control; we seem to have criticism of not permitting people to come into Canada. I was wondering if there was not something ---

PROF. WALMSLEY: I think it does not seem at the present time there is a surplus of population in Canada; still this problem of world population is

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Walmsley

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going to very seriously affect our Canadian scene. We shall arrive at the place soon where we cannot put the barriers around us and keep them out. I think many of you have read the article in Saturday Night, "Standing Room Only", something of that nature, where, following the natural increase in population through the next 30 to 40 years, it will create, really, a startling situation.

COMMISSIONER McCUTCHEON: We should get crowded ourselves and the other people would not have room to come in.

MR. FIDLER: May I suggest that one field of our concern which may be related to your question is the fact we know that people who have sufficient income are able to get all the information and assistance that they need in this field through their regular consultation with the medical profession. However, there is a segment of our society that is not able to call on that kind of service and this is a segment that may be, from the point of view of the social need of Canada, the one that ought to have this information made available.

I think it is the concern of those of us who are connected with this Association that this privilege of having this assistance should be made more widely available.

COMMISSIONER McCUTCHEON: Is that true today when about 95% of the births occur in hospitals? In a hospital there would be a physician attending and surely the information is available at that time if



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Fidler

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MR. FIDLER: I know we made, through the United Church of Canada, a spot survey of several areas of Canada a year ago through the public health services and the various volunteer services and we found there was a great reluctance to provide this information because of the present law.

COMMISSIONER McCUTCHEON: The present law does not prevent anyone from providing the information, not as I read it.

MR. FIDLER: You will notice it says:
"Everyone commits an offence who knowingly, without lawful justification or excuse, offers to sell, advertises, publishes an advertisement of or has for sale or disposal ---"

COMMISSIONER McCUTCHEON: A doctor does not sell, he does not advertise, or they would put him out of the profession; he does not do any of these things.

MR. FIDLER: It is a fact, I think, that ---



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4 THE CHAIRMAN: The word "construction"
5 is governed by the preceding word.

6 MR. FIDLER: I think the situation
7 actually is, however, that public health nurses and others
8 who are working in this field are reluctant to give the
9 information because of the record of past court pro-
cedures.

10 Now we know that a notable case of
11 25 years ago -- actually, I believe that in the final
12 instance the charge was withdrawn and there was no clear
13 judgment given but this has actually overshadowed the
14 willingness of many people who might give information
15 through clinics, and through public services like this
to withhold.

16 COMMISSIONER McCUTCHEON: I was
17 questioning your statement. I don't see anything here
18 that prevents the physician who is requested to give
19 the information, to give it. I don't see anything here
20 that prevents the physician proffering that information
21 to his patient. I don't know what areas you surveyed.
22 Certainly in most of Canada children are born in
23 hospitals under the supervision of an attending physician
24 and the information is available if the physician
chooses to give it.

25 Dr. Dodds has not asked for the
26 protection of the Canada Evidence Act this afternoon.
27 If it is an offence, he has admitted that he commits
it regularly.

28 THE CHAIRMAN: I don't think it is an
29 offence.
30

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Dr. Bodde has not asked for the

protection of the Canada Evidence Act this afternoon. If it is an offence, he has admitted that he commits it regularly.

THE CHAIRMAN: I don't think it is an



Fidler

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4 COMMISSIONER McCUTCHEON: I don't think
5 it is an offence either.

6 MR. BAIN: Should it be an offence for
7 a pharmacist to maintain a stock of materials that are
8 requested by people?

9 THE CHAIRMAN: I suppose I can answer
10 that by saying there are some groups who would like
11 pharmacists to stock narcotics. You have just got to
12 add to your own question. Related to what it is.
13 Merely putting a question in that way, does it take you
14 anywhere? Because it would follow that if the Code was
15 amended in the way you suggest, then I suppose that
16 could be stocked along with the ice cream cones and the
17 rest that is in the drug store.

18 COMMISSIONER McCUTCHEON: How serious
19 a problem is this? The pharmacist is not prosecuted
20 under this section.

21 MR. BAIN: It would seem sir that the
22 pharmacist is subject to prosecution at any time under
23 this.

24 COMMISSIONER McCUTCHEON: When was the
25 last pharmacist prosecuted in Canada under this section?
26 Or has there even been prosecution of a pharmacist under
27 this section?

28 MR. BAIN: Mr. Chairman, this would
29 still seem to put the whole procedure under a kind of
30 cloak, if you like, of illegality. Whether the pharmacist
feels he is open to prosecution on that point, this is
his ethical procedure and it is rather a poor law which
can be broken at will and not either enforced or amended.



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4 This is one of our concerns, that this
5 should be a matter which is of considerable public
6 importance, public significance and that it should not
7 be under this kind of cloak or suggestion of illegality
8 or immorality, whatever the case may be.

9 The mere fact that pharmacists are
10 distributing these articles and not being prosecuted
11 would not seem to be either good, from the point of view
12 of the law or from the point of view of public interest.

13 COMMISSIONER McCUTCHEON: If we are
14 going to wipe out all the laws that are not enforced,
15 we will have a very busy time going through the statute
16 books.

17 DR. DODDS: This law has inhibited the
18 formation of an Association such as ours until this time
19 despite the fact that we have living in our community
20 Mr. George Cadbury a member of the International Planned
21 Parenthood Association. He has been here several years
22 and this is one of the few countries that have not
23 formed such an Association and apparently because of this
24 law. In coming together to attempt to form this
25 Association this was our major stumbling block, this
26 law, the giving of instructions was illegal and in fact,
27 the clinic that was formerly in the Women's College
28 Hospital up to the time of the court case just mentioned
29 some 25 years ago was subsequently closed because of the
30 bad publicity associated with this and since it comes under
the giving of this sort of information to families, in
a town in Ontario, came under scrutiny as an offence
tending to corrupt morals which is part of the Criminal



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Bain

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Subsequent to this the clinic in the Women's College Hospital was closed. There are two clinics that we know of in Canada, small clinics and rather ineffectual. In other countries these clinics are very active.

THE CHAIRMAN: Well thank you gentlemen. You have put forward your views and we are here to listen to you. We have documented your brief. The material is here. It will receive consideration in due course.

---Luncheon adjournment.



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---Upon Resuming at two o'clock p.m.

THE SECRETARY: Mr. Chairman, the first submission this afternoon will be that of the Society of Obstetricians and Gynaecologists of Canada. It will be Exhibit No. 360, and Dr. Maughan will introduce this group to the Commission.

---EXHIBIT NO. 360: Submission of the Society of Obstetricians and Gynaecologists of Canada.

SUBMISSION OF
THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA

APPEARANCES:

DR. G.B. MAUGHAN,
DR. A.H. MACLENNAN,
DR. A.D. KELLY,
DR. F.P. MCINNIS.

DR. MAUGHAN: Mr. Chairman and Honourable Commissioners: With your permission I should like to introduce Dr. A.H. MacleNNan of Edmonton, who is President-Elect of the Society of Obstetricians and Gynaecologists of Canada. Dr. F.P. McInnis, the Secretary, and Dr. Arthur D. Kelly, Secretary of the Canadian Medical Association.

We are the officers of the Society of Obstetricians and Gynaecologists of Canada, which was incorporated in 1945. The purpose of the Society is to

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promote, cultivate and encourage the art and science of obstetrics and gynaecology in Canada. In our seventeen-year history we have met annually and maintained a secretariat. We started with very few members. We are presently about 300 members of the 760 certified obstetricians and gynaecologists in the country. It is expected that within one year this number will be increased to almost 400, which will represent a majority of the obstetricians and gynaecologists in the country.

A year ago, when we first were apprised of the formation of the present Royal Commission, it was decided that our Society should present a brief, and Dr. MacLennan was chosen as Chairman of the Committee to prepare the brief, and he with one or more representatives in each of the Provinces of the country, has prepared the brief which has been submitted to you.

With your permission, I would like Dr. MacLennan to read the summary and recommendations, and act as the Chairman of our Committee.

THE CHAIRMAN: That will be very satisfactory.

DR. MACLENNAN: Mr. Chairman and Members of the Commission: As I read these points in the summary, if I may, I will make a few explanatory remarks, which may obviate some of the questions that would be asked. I would also indicate, which we unfortunately didn't do in the presentation, the individual paragraphs in the body of the brief that are referred to.

The magnitude of Obstetrical and Gynaecological care as a segment of the total health



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The magnitude of Obstetrical and
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services provided to our female population. That is Paragraph 1 in the submission, and this implies that in many instances two lives are to be considered. In addition, approximately nine-tenths per cent of this number of pregnancies would be expected to terminate by abortion. In addition, the field of gynaecology which is both medical and surgical comprises a great deal of the care which the female population receives, and up to 30% of surgery in some hospitals falls within the field of gynaecology. In the year 1959, there were 263 maternal deaths and approximately 14,000 perinatal babies died in that year.

This care is provided largely on the principle of Private Practice. This is particularly important in the provision of Obstetrical and Gynaecological care because of the personalized nature of these services.

In remote areas with sparse population and inadequate means of communication and transportation - medical care is inadequate.

These two items are covered in Paragraphs 19 to 23. These areas of inadequate care are particularly in the Northern parts of the Provinces, particularly the Western Provinces and the North-West Territories, and the Northern portions of the Eastern Provinces.

Alterations in the pattern of practice - growth of "group" practice.

This is Paragraph 26 of the submission. There are two areas here to be pointed up. The first is there is a diminishing percentage of doctors today who attend maternity cases as compared to former years. This



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is due considerably to the increase in specialization in various fields, particularly in urban centres, but there is a very definite growth of what we call group practice, particularly among the general practitioners. Many groups combine general practitioners and specialists, and to a lesser degree there are groups of specialists in obstetrics and gynaecology binding together in order to carry out their practice. This group practice is probably more prevalent in the Western part of Canada than it is in the Eastern portion of Canada, and is more prominent in certain cities, such as Winnipeg, and in general in the Western Provinces.

Growth of specialism in Obstetrics and Gynaecology.

This refers to Paragraph 27 and 28 of the submission. We feel this is one of the important factors that has affected the maternal and foetal mortality rates.

Where specialist care is available - increasing demand by the public for this quality of care in normal obstetrics.

This refers to Paragraph 28 of the submission. We feel that this is desirable, and that we should allow, if possible, this situation to continue and expand. In general, it is the feeling of our group that specialists should not be restricted only to act as consultants if we feel that the mothers are to get the best possible care. We sometimes hear the remark that specialists should be consultants only, but it is in general our feeling that this should not apply.

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Inadequate specialist services in some areas for consultation and supervision.

This refers to Paragraph 29 and 30 of the submission. In Canada in 1960 there was one certified obstetrician and gynaecologist for every 24,000 people. We feel that an ideal ratio would be one to 10,000. There are certain areas, however, where we feel consultant services have been inadequate, and chiefly they are in Newfoundland, New Brunswick and Nova Scotia, and in other parts of the country. It varies from Province to Province. In Ontario, and I think in all the Western Provinces, this deficiency lies chiefly in the small centres, where there may be 15,000 people or less.

Again, the situation is different in the Province of Quebec.

Increase in hospitalization for delivery.

I refer you to Paragraph 21 and Appendix F at the back of the brief. The drop in maternal and foetal mortality exactly parallels this trend for women to be confined in hospitals, and we feel this is one of the most important factors as a contribution to the improvement in maternal and child health welfare.

Too many small hospitals which are inadequately equipped and without consultation services.

Throughout the country there are very many hospitals in various places that supply one, two or three doctors only. Many of these hospitals are uneconomical to operate at a proper level, and it is a general



...inadequately supervised and supervised.

This refers to paragraph 29 and 30 of

the submission. In Canada in 1960 there was one
certified obstetrician and gynaecologist for every 22,000
people. We feel that a better ratio would be one to

10,000. There are certain areas, however, where we feel

consultant services have been inadequate, and chiefly
they are in Newfoundland, New Brunswick and Nova Scotia,
and in other parts of the country. It varies from

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and local mortality formerly persists and trend for
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the improvement in maternal and child health.

For many small rural areas

inadequately equipped and without consultation services.

Throughout the country there are very

many hospitals in one place that supply one, two or
three doctors only. Many of these hospitals are now down

level to compare at a proper level, and it is a general



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feeling that probably there should be a minimum on the number of beds that are built when these small hospitals are being established.

THE CHAIRMAN: On that point, Dr. MacLennan, do you have a choice? You are accepting that it is better that there be an increase in the hospitalization for delivery. Has not the fact of all these small hospitals been in considerable measure responsible for this increase that you have just spoken of, to the 93%?

DR. MACLENNAN: That is true, sir, but there are areas where there may be small hospitals, reasonably close together, that probably should have been consolidated into one, where there is a distance of 20 to 25 miles. I am speaking of the area with which I am more acquainted, the Prairies.

THE CHAIRMAN: Those are the ones I am thinking of, right in Saskatchewan.

DR. MACLENNAN: There is no question about those, as far as the statutory care.

THE CHAIRMAN: These small hospitals, I think in the main, and without being critical of them, have become maternity wards, rural maternity wards?

DR. MACLENNAN: That is true, sir.

THE CHAIRMAN: Are we to understand that you don't want to see that continue?

DR. MACLENNAN: I think that if they were building new ones, we feel that they should be a little larger. You could better equip the hospitals from the standpoint of economy, and it is particularly important



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am thinking of, which is Saskatchewan.

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that you don't want to see that continued?

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little better. You could better equip the hospitals I am

the standard of economy, and it is extremely important



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that the standards and equipment be maintained if they are going to perform surgery. If they refer their problem cases away ----

THE CHAIRMAN: That is another story. I see what you mean. On the surgical aspect I think there would not be any necessity to stress it.

DR. MACLENNAN: We certainly acknowledge that what you say is certainly true, that it has allowed women to be delivered in hospitals.

The efforts which have resulted in the marked reduction in maternal deaths coincides with the growth of our specialty. In addition to the services rendered to their patients by qualified obstetricians, their influence as consultants and as supervisors of hospital departments has contributed materially to this progressively improving situation.

Coincident but less marked reduction in "foetal loss."

Paragraphs 26 to 31 are covered by this. At the same time there has been a coincident, but a less marked reduction in foetal loss. Some of the statistics that indicate this improvement. From a standpoint of maternal mortality, the risk of pregnancy in confinement in 1935 was one death in 196 deliveries. In 1939 it was one in 232. In 1949 it was one in 666. In 1959 it was one in 2,000.

From the standpoint of foetal loss in 1931 it was 58.4 per 1,000 live births. In 1949 it was 43.8 per 1,000 live births. In 1959 it was 31.7 per 1,000 live births, including the Yukon and the North-West Territories.



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Now, the implication, we feel, is that while these statistics pertain and reflect only the actual maternal and foetal loss, the improvement that is manifest, we feel, is an indication of the improved quality of care, and that not only the mortality, but the morbidity, which is much more difficult to assess, has also been simultaneously reduced.

Role of Voluntary Committees of the profession in the study of Maternal and Perinatal Infant deaths in the improvement of Maternal and Infant Welfare.



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THE CHAIRMAN: Have you taken out figures eliminating the North West Territories in foetal and maternal deaths, in appendices B and C?

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DR. McINNIS: No, we didn't do that, but that could be done.

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THE CHAIRMAN: I don't know what the volume is, but the figures are so much out of line, 4.2% -- you are a fraction of 1% all the way down the line and then you go to 4%, 5% in 1958, 1959.

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DR. MACLENNAN: Of course, these figures were not available for the Yukon previously, North West Territories.

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THE CHAIRMAN: You get the same with stillbirths, and so forth.

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DR. MAUGHAN: Well, I believe, Mr. Chairman, the volume is so small it wouldn't materially affect the rate for the whole of the country.

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DR. MACLENNAN: Then one further observation with regard to 10 and 11.

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It is our feeling that the factors that have been concerned in this reduction are four. First of all, the increase in specialization of obstetrics and gynaecology. Second, the ratio of hospital deliveries; three, the advent of antibiotics, other drugs, the availability of blood for transfusions and improved anaesthesia; and the fourth factor we think is important is mentioned in number 12, the professional study committees in their study of the factors pertaining to maternity and foetal loss.

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S 13. The role of ancillary services in providing

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The role of ancillary services in providing



care for the remote areas.

In this we refer to the fact that public health nurses in the remote areas do carry out a valuable service to the public, especially in sparsely settled areas where there is no attention; and it also refers to the means of transportation of the patients to gynaecology centres.

S 14. The importance of the relationship of the Gynaecology to the reproductive function.

This is covered in paragraphs 45 to 48. We refer here to the fact that we have moved forward in the practice of obstetrics and gynaecology from the day when a great deal of gynaecological surgery was done by the general surgeon, and today that has changed; as the older people leave the field, trained obstetricians and gynaecologists enter practice.

S 15. The variation in operation of "Cancer Programs" in different provinces.

This is covered in paragraphs 49 and 50. More and more in Canada cancer diagnosis and therapy is carried out in cancer centres. In general the quality of the care is excellent throughout the country. The chief variation lies in the manner of administration and a variable means to pay for this service. However, it is a fact that there is no one who is precluded from the best possible care for cancer by reason of their ability to pay.

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these cancer clinics in any field where there is more than one method of therapy. There are needs of consultation between the radiotherapist and gynaecologist. S17. It has been a The need for a Canada-wide cytology screening program in early detection of cancer.

I might say, Mr. Chairman, that two eminent health authorities in the field of cancer attended a meeting in Vancouver last October and they made the comment that they knew of no other program within their knowledge that was as excellent in detection and management of gynaecological cancer as carried out by the British Columbia Cancer Institute. They have had a cancer detection program for some 10 or 12 years that is not surpassed anywhere, and as the result of this they have reduced the incidence of cancer of the cervix in the Province of British Columbia by at least 30%, which is a fabulous contribution to the welfare of the people.

COMMISSIONER BALTZAN: Do you mean the diagnosis was not yet established?

DR. MACLENNAN: Through their efforts in detecting these pre-cancerous lesions they have reduced, between 1955 and 1960, the actual cases of cancer of the cervix by 30%.

THE CHAIRMAN: It must be reduced in proportion to what it was before?

DR. MACLENNAN: Yes, but invasive cancer, new cases of invasive cancer. We feel that this could be carried out to a much greater extent in other parts of the country.

S 18.

Importance of Blood Banks in the



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MacLennan

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Obstetrical and Gynaecological practice.

This, of course, has been made possible by the efforts of the Red Cross Blood Transfusion Service, and it has been a fabulous contribution to the obstetrical patients particularly.

Our recommendations, sir, are as follows:

R 1. Continuation of provision of maternity and gynaecological care on the principle of Private Practice.

R 2. Expansion of specialist services to areas where this service is not available. In some areas subsidization may be required. It is our feeling that due to the variation that exists from province to province that no specific plan can be recommended that could be applicable to all areas. We feel this could be achieved between the co-operation of the different professions and the various provincial departments of health.

R 3. Continue the emphasis on, and improve the teaching in Obstetrics and Gynaecology during Internship of Medical Graduates.

R 4. Expand and improve continuing post-graduate education in Obstetrics and Gynaecology for General Practitioners. These are matters which we are really not seeking the aid of this Commission; we are bringing them to your attention only. This is an expression of our views and is the responsibility of the teaching authorities and the practising profession.

THE CHAIRMAN: Well, it is relevant in

Obstetrical and Gynaecological practice.

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teaching authorities and the practising profession.

THE CHAIRMAN: Well, it is relevant in



MacLennan

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4 this way, that we have a study underway under Dr.
5 MacFarlane and a group of distinguished associates.

6 DR. KELLY: Sir, it is further
7 pertinent to the interests of this Commission that the
8 availability of hospital insurance has perhaps weighed
9 more heavily in this field of obstetrics and gynaecology
10 than any other. The fact that each hospitalized patient
11 is to all intents and purposes a private patient is
12 important to the under-graduate and post-graduate
13 teaching, because here I think is where privacy is
14 more important than any other.

15 DR. MACLENNAN:

16 R 5. Expand Maternal and Infant Welfare
17 studies and other means of "self-scrutiny" by the
18 profession. Again, we feel this is a professional
19 matter. We feel that this is one of the important ways
20 in which we can further improve the quality of care.

21 R 6. Expand the training of Public Health
22 Nurses to serve in remote areas unattended by medical
23 doctors.

24 DR. KELLY: We are not necessarily
25 recommending the practice of introducing mid-wives
26 specifically, but there are areas where these people
27 provide a marvellous service to the community.

28 THE CHAIRMAN: You have a system,
29 basis for it in Alberta?

30 DR. MACLENNAN: Yes, we do. It is really
a stopgap in sparsely settled areas until they are
settled sufficiently and have medical attention.

COMMISSIONER GIRARD: And you go so far



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MacLennan

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4 as to recommend that where nurses are going to be
5 employed in outposts where no doctors are available, that
6 they should see that they have a training along this
7 line, similar to this.

8 DR. MACLENNAN: They do in Alberta.

9 DR. McINNIS: This is what we so desire.

10 COMMISSIONER GIRARD: And if they
11 are employed by the government the government should
12 see that they get that training. It is the responsibility
13 of the employer not to send them out to these areas
14 until they are qualified to do this sort of work.

15 DR. MACLENNAN:

16 R-7. Expand and improve educational
17 facilities for training of hospital personnel such as
18 supervisors for case rooms and nurseries. Now, the
19 post-graduate training of nurses is a complex subject,
20 it covers the training of people who are interested ---

21 THE CHAIRMAN: I think we might say
22 that we probably heard as much on that subject as on
23 any other one subject that has been before us.

24 DR. MacLENNAN: Mr. Chairman, if I
25 might say one thing. We feel that in the hospital, in
26 the operation of the hospital, there is no area where
27 the quality of the nurse is more important than in the
28 case room, and as opposed, say, to an operating room or
29 a changeable ward, we feel that the case room girl who
30 is well qualified is in a class by herself and has a
responsibility that no other person has to take. In
many places there are no interns, the doctor cannot always
stay 10 or 12 hours with a patient and he has to rely on



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DR. MACLEAN: They do in Alberta.

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responsibility that no other person has to take. In

many places there are no interns, the doctor cannot always

stay 12 or 13 hours with a patient and he has to rely on



MacLennan

12198

the judgment of the nurse. We feel that they are a very special group.

R 8. Expand and improve facilities for transportation - such as air ambulances - of patients from remote areas to centres for adequate hospital facilities and consultation services.

R 9. Ensure the provision of prenatal care to every expectant woman. This, we feel, is absolutely essential if we are to further reduce our maternity and foetal fatality. In some areas consultants are available and in some areas nurses travel and carry out this function, but there is a great area where we feel public education is important to bring to the attention of these people the need to seek care.

R 10. Promote the extension of voluntary complete medical insurance coverage - to include antenatal and postnatal care. I am sure, sir, that you have had a great deal of information presented on this matter of insurance. I think that we probably did not differ in our attitude than other members of our profession, except that over the years many commercial carriers fail to give obstetrical coverage or they give coverage pertaining only to delivery and give no consideration to antenatal care and postnatal care.

In general we favour the system or the plan with which we are most familiar, namely, the voluntary plans, which in general give ample coverage, which are sponsored by the medical profession, and, of course, in all these medically-sponsored plans, in many of them the patient who seeks this special service has to pay an additional



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3 fee.

4 R 11. Expansion of this type of coverage to
5 those presently uninsurable by reasons of inadequate
6 income, chronic illness, etc., but subsidization of the
7 cost of premiums from public funds.

8 Numbers 12, 13, 14, 16 and 17 I am
9 going to ask Dr. Maughan to discuss.

10 R 12. Expansion of facilities to train more
11 medical graduates in the Specialty of Obstetrics and
12 Gynaecology to meet our present additional needs, as
13 well as the future requirements, because of the
14 increasing population as well as the increasing demand
15 for teachers in our medical schools.

16 R 13. Expand the principle of establishment
17 of Obstetrical and Gynaecological Departments in non-
18 teaching hospitals under the supervision and direction
19 of specialists in this discipline.

20 R 14. Provide assurance of adequate facilities
21 (including patients) for training of General Practitioners
22 and Specialists in Obstetrics and Gynaecology. The
23 Department of Obstetrics and Gynaecology must have a
24 teaching unit consisting of a group of beds in a
25 designated area of the hospital in which the investiga-
26 tion and treatment of the patient is the delegated
27 responsibility of the Resident, Intern, and Clinical
28 Cler, working under the direct supervision and guidance
29 of an Obstetrician and Gynaecologist, who is a member of
30 the organized teaching staff.

R 15. Consideration should be given to "part
time" remuneration for those in charge of Hospital



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R 15. Consideration should be given to "part time" consideration for those in charge of Hospital



MacLennan

12201

Obstetrical and gynaecological Departments to allow time away from practice for supervision, teaching and clinical research.

R 16. Maintenance of present scholastic standards in medical school and present standards of post-graduate training.

R 18. Continuation and expansion of present facilities for fundamental and clinical research.



12.11

MacLennan

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Maughan

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DR. MAUGHAN: Mr. Chairman, as I am sure you and the Commissioners have been told, we have, over the last 10 years or so, noted a decrease in the number of good students applying for entrance to the various medical schools in this country. There are more glamorous callings, apparently, open to them now. Still, we find that there is an adequate number of applicants for medical training. Most schools have more applicants than are readily acceptable. It is our belief that we should not lower our scholastic standards for admission to medicine, otherwise, in the long run, we lower the quality of medical care to the public that is provided by these entrants to medicine who may not have good scholastic attainment.

Now, at the same time, each group who do graduate from medical schools, have the problem of training and training that will make them into good practitioners in obstetrics and gynaecology. In many centres it is becoming increasingly difficult to find the clinical material with which to train them. As has been pointed out earlier, the hospitalization insurance has made private patients of very many people who are admitted to hospital and really there are only two centres in Canada now who find they still have adequate numbers of standard ward care or public ward, the old term, public ward patients, for training of undergraduate students; for training of interns in their first year of school and the training of residents specializing in obstetrics and gynaecology.

In any system that evolves for the care



Maughan

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3 of obstetrical and gynaecological patients, it is our
4 belief that we must always look to this availability of
5 clinical material for the training of these students.
6 We note, even in a place where there is a large volume
7 of public ward patients, in my own clinic in Montreal,
8 that certain of our medical students' wives insist on
9 going to other hospitals rather than being in the
10 teaching hospital where they are afraid they will be
11 taught on at the time they have their baby.

12 This refers back, again, to the perso-
13 nalized nature of obstetrical care and exactly how to
14 have an adequate amount of clinical material for good
15 teaching and training of interns and residents, we are
16 not quite sure, outside of the large centres where
17 there are enough low income people who are interested in
18 getting this standard ward care.

19 We cannot turn out a good obstetrician-
20 gynaecologist who has just read the books; he must have
21 done the procedures, first of all, under very close
22 supervision and later on, under looser supervision.
23 If he is going out as a specialist in obstetrics and
24 gynaecology he must be able to cope personally with the
25 emergencies that arise in our ward care which probably
26 arise more often than they arrive or arise in any other
27 branch of medicine.

28 We would hope that people, all people,
29 will not be so carefully insured that they will all
30 insist on their own practising obstetrician-gynaecologist;
that they will be prepared to accept the teamwork
principle in hospital care and that under the supervision



Maughan

12204

of the certified practising obstetrician-gynaecologist that they will accept as the procedure, the actual procedure of delivery and/or operating will be done by one of the resident staff qualified but not certificated.

THE CHAIRMAN: It would appear to pose a difficult administrative problem, administrative to begin with and perhaps more fundamental even to get any levels in insurability in that respect.

DR. MAUGHAN: It is a very difficult problem and I say there are only two centres in the country that are not being faced with it at this time.

THE CHAIRMAN: I am afraid we will have to look for another solution rather than trying to find one on different levels of insurability because I think you would wander into a riot if you tried that.

DR. MAUGHAN: The other solution is that question of acceptance of the principle of teamwork in actual operative procedures or delivery of patients.

THE CHAIRMAN: Dr. Baltzan may be able to confirm it apparently is possible through education, through the education process of the patient to achieve this because, in Saskatchewan, the thing has been going on now for 13, going on 14, years, and they are training doctors in that area.

DR. MAUGHAN: Our problem is particularly with the personalized nature of obstetrics which makes it even more difficult than in general surgery.

THE CHAIRMAN: It is the most sensitive field of the lot.

DR. MAUGHAN: That is right. Item 18,



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THE CHAIRMAN: It is the most expensive

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DR. MAUGHAN: That is a fact. Item 18,



Maughan

12205

Recommendation 18, to which Dr. MacLennan referred, the education and expansion of present facilities for fundamental and clinical research is something that is very dear to the hearts of all the teachers of obstetrics and gynaecology across the country.

I have written, relatively recently, in my annual report to the university, that man is essentially and basically selfish and he is interested in what might happen to him in the future and much less interested in what did happen to him in the past. Man is willing to contribute sums of money for investigation into heart disease, cancer and other ails that may afflict him, after he gets to the point in his financial affairs and life where he can contribute.

But, trying to find funds for clinical and basic research in obstetrics and gynaecology is a completely different problem because the people who are vitally interested in this problem are young people who do not have the funds to contribute.

We, at the present time, are finding extreme difficulty getting funds for good research programs; some of it is available through various foundations, particularly American foundations, and some of it is available through the child maternal hygiene development of the national health and welfare grants.

Our Society has made recent protest to the Medical Research Council about their failure to support many of our research projects. They feel that these should be supported by the marital and child hygiene development; marital and child hygiene divisions

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Maughan

12206

sometimes feel they are a little too basic to be supported by them and should be by M.R.C. We fall between the two schools and we do have difficulty with research funds.

I do believe that in any program of research, the support, particularly obstetrical research, has to be primarily considered because all of us have an idea that the most important time of our lives is now or next year or 10 years from now whereas in actual fact the most important parts of our lives were the eight-and-a-half to nine months before we were born and the first ten minutes of our lives.

It is that period of time and our nutrition at that time, particularly our oxidization at that time, that sets our whole future. The individual who is well-oxygenated, well-nourished, up to and including his first ten minutes of life, probably has a good future ahead of him.

It is our hope that in any recommendations for research funds, your Commission will remember that obstetrics and gynaecology, where it is a perfectly normal procedure, so-called, still it is a very little-known procedure.

THE CHAIRMAN: Thank you very much.

DR. MACLENNAN: No. 17 is to promote and encourage the trend to delivery in hospital. Our objective is to have every mother delivered in hospital. I would refer you again to Appendix F which graphically portrays the welfare of the mother and baby. I might add, Mr. Chairman, one note, with reference to No. 15

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It is our hope that in any recommendations

for research funds, your Commission will remember that obstetrics and gynecology, where it is a perfectly normal procedure, so-called, still it is a very little-known procedure.

MR. WASHINGTON: Now, it is to promote

and encourage the trend to delivery in hospital. Our objective is to have every mother delivered in hospital. I would refer you again to Appendix T which graphically portrays the welfare of the mother and baby. I might add, Mr. Chairman, one more, with reference to No. 10



MacLennan

12207

which reads:

"Consideration should be given to
'part-time' remuneration for those
in charge of hospital obstetrical
and gynaecological departments to
allow time away from practice for
supervision, teaching and clinical
research."

We refer here to hospitals that are
not university hospitals that do not have professorial
personnel in actual charge of departments. These are
private practitioners who perform these functions and
when we suggest that there should be some form of part-
time remuneration we wish it understood that it is not
payment for medical care but for the time it requires
from their practice to carry out teaching supervision
and administration of the department.

No. 19 reads:

"Closer liaison between members of
the provincial divisions of the
Canadian medical profession and
provincial Departments of Health."

It appears from reports from different
provinces that there is quite a wide discrepancy in the
degree of liaison that exists between the profession
and the Departments of Health. In various areas this
liaison is excellent in some provinces and in others
we understand it is not so good but we do feel that
even closer co-operation between these two bodies will
result in a further improvement in the quality of health



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MacLennan

12208

services that can be achieved in this field.

THE CHAIRMAN: Thank you, Dr. MacLennan.

The different patterns emerge as we hear these submissions and I must say that this one that you have adopted this afternoon of commenting as you go along and interpolating as Dr. Maughan did with ideas is very helpful and very easy to follow and cuts down the questions because the very things that half-a-dozen questions might have been asked about have already been faced up to as we went along this afternoon. Dr. Baltzan?



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THE CHAIRMAN: Thank you, Dr. Macfarlane.

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very things that half-a-dozen questions might have been

asked about have already been faced up to as we went

along this afternoon. Dr. Halliday?

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12209

COMMISSIONER BALTZAN: Gentlemen,
many of us are relieved that you separated the affairs
of the inter-professional matters from those of the
broader bases and that will cut down the questions, Mr.
Chairman.

In R-10 you refer to the importance
in relation to prenatal and post-natal care and that is
appreciated. I want to compare that with some discouraging
things. We had the statistics on infant mortality in
Canada compared with comparable countries. Is this
element a contributory matter to this poor standing that
Canada has amongst the better nations in relation to
infant mortality?

DR. MACLENNAN: I think that probably
it is the cost of care, not only in a small percentage
of the people who do not get care, that the cost is the
factor.

We feel in this R-10 that in many
respects obstetrical -- the public has been deceived to
some extent in buying health insurance. They buy a policy
that will provide them with surgical care, but they are
denied obstetrical care or get inadequate obstetrical
coverage in their policies that they buy and there should
be, if we are going to have any form of insurance to
cover people and their medical care, this is one area
they should certainly bring up to the standard they have
in other fields of medicine.

THE CHAIRMAN: Does this criticism
apply to the doctor-sponsored plans as well?

DR. MACLENNAN: Not to my knowledge, sir.

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THE CHAIRMAN: Does this criticism

apply to the doctor-sponsored plans as well?

P. MACLENNAN: Not to my knowledge, sir.



MacLennan 12210

The profession, to my knowledge, has accepted the fact --

THE CHAIRMAN: You use the words
"voluntary prepaid" which covers both.

DR. MACLENNAN: We feel that there
is and always will be a large percentage of the maternity
care which will be carried out by general practitioners
and we accept that. The profession accepts the fact
if patients seek the care of the obstetrician, who is a
specialist, that he has to collect from the patient and the
patient understands that and is quite willing to pay for
it.

I know in our City in Edmonton that
over half of the women are delivered by certified men in
the City of Edmonton and 55% of the population are covered
by M.S.I., so there is a large number of these people
paying the additional fee voluntarily.

COMMISSIONER BALTZAN: And that includes
prenatal?

DR. MACLENNAN: Everything, prenatal
and delivery and post-natal care.

COMMISSIONER BALTZAN: Is it showing
any improvement in your statistics so far?

DR. MACLENNAN: Without being immodest,
Dr. Baltzan, I think we have as good a record as any
place in Canada.

COMMISSIONER BALTZAN: I don't question
that. I am only trying to compare the kinds of benefits
that you wish these people to have. Dr. Maughan, speaking
about these units, I think we had discussed this before,
teaching units that you mentioned. My question to you is,



Maughan 12211

How successful will you be in implementing, in inaugurating, organizing the segregated --- I use the word "segregated" in parenthesis --- units for just that purpose in the hospital, especially when there is an increased coverage and more people for the prepayment schemes?

DR. MAUGHAN: At the moment, as you know, sir, we have this segregation in standard ward care wards and in semi-private and private rooms. That is gradually disappearing in new hospital construction.

However, it is believed that a certain area of the so-called multiple occupancy rooms can be laid aside for this particular purpose and those put aside for this particular purpose, most standard ward care patients can be channelled or funnelled into these areas. Again, it is going to depend on the acceptance by the public generally of the teamwork principle in their medical-surgical or obstetrical-gynaecological care.

COMMISSIONER BALTZAN: I am very much interested in that, because I am always thinking about some experience that has already been referred to by the Chairman in certain other areas --- we won't name them exactly --- where it has been found, but that is not an absolute requirement. Teaching is possible under the circumstances as they exist now and it is possible or was made possible chiefly because of the improved rapport between the attending physician or surgeon and his patient, so it's something like 15 years that question has never come up, that we must build separate teaching units.

DR. MAUGHAN: By the same token, sir,

Maughan 12111

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DR. MAUGHAN: By the same token, sir,



Maughan 12212

it is my belief that the areas in which it has been shown to work are almost completely teaching units, are they not?

COMMISSIONER BALTZAN: Teaching hospitals as well as universities.

DR. MAUGHAN: Teaching hospitals rather than teaching units within the whole hospital.

THE CHAIRMAN: All the beds in the whole city with no place else to go.

COMMISSIONER BALTZAN: I think I have asked you before whether or not the patient will be necessary in the whole teaching system in line with a new --- with a change in the entry of patients into the hospital, that the teaching may even carry over to where some of these personal things will not come into the hands of those people who align themselves as parenthesis to this.

DR. MAUGHAN: I believe that it might well come to that, yes, sir.

COMMISSIONER BALTZAN: That will be a subject for consideration by the Educational Committee. One last question to you, sir. You speak about establishing obstetrical-gynaecological departments. That is almost obligatory under the system of accreditation of hospitals, or isn't it yet?

DR. MACLENNAN: It is part of the process of accreditation, but accreditation is not that precise. If we have any hospitals ---- if you seek to get qualifications to train a man, to have his training recognized to an advanced degree, then these are set out by the Royal College, but you can have the same hospital,



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MacLennan 12213

and it can be an accredited hospital by the Canadian Council, but if you are not --- you do not have to have a gynaecological ward if you are not training people in post-graduate work. If you want his training, for instance, in one hospital --- a hospital, if a man is to get credit for his year in obstetrics and gynaecology, working towards his certification or fellowship, then you must have a gynaecological department, but if you have a hospital that is just training just general internship, it is not mandatory. They are working towards this.

COMMISSIONER BALTZAN: So that some hospitals are accredited say, in one, two, three departments or two departments or all departments?

DR. MACLENNAN: That is right.

COMMISSIONER BALTZAN: Only those hospitals that are departmentalized and recognized by the Royal College of Physicians and having some affiliation with the University --- there is no difficulty there?

DR. MACLENNAN: That is right. When they are affiliated with the University there is no difficulty. In the main university cities there is a problem because if you have a department and have a man who is, let us say, assigned to the position or as chief or director of this Department, unless it is a well-organized department and it is established with some authority, he has not got supervision over the quality of work that is done in the hospital.

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MacLennan 12214

the non-teaching hospitals, if they are going to get quality of care. In other words, you can then control the work that is done in that department and by whom it is done.

THE CHAIRMAN: Gentlemen, I do not want to interfere with an interesting discussion, but we have a special project going on: Medical education and the people we have are very well-qualified and they are being asked for a discussion on these very questions we are discussing here this afternoon. It's just a matter of duplication.

COMMISSIONER BALTZAN: Thank you very much. You answered my question.

THE CHAIRMAN: Thank you very much, Dr. MacLennan, gentlemen. As I mentioned, it is not a matter of cutting off discussion. There are other phases, other aspects of medical education, the matter of bursaries and research, etcetera, are all being dealt with in special categories and we have had considerable discussion as we went along, and I think that not much purpose can be achieved --- we are just repeating in that sense, so I would ask you to appreciate that and at the same time we thank you very much for your attendance here this afternoon and for your help.

DR. McINNIS: We just want to stress the fact that when they are implementing these things obstetrics and gynaecology are not forgotten.

THE CHAIRMAN: Now, Doctor, it is entirely in your own hands. You know the man. You know



Maclean 1931

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the fact that when they are implementing these things

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THE CHAIRMAN: Now, ladies, it is

entirely in your own hands. You know the man. You know



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Mr. MacFarlane. If you cannot talk to him and tell him about it, you are not as good as we think you are.

THE SECRETARY: The next submission, Mr. Chairman, is that of the Society of Obstetricians and Gynaecologists of Toronto, which will be known as Exhibit 361. Dr. Allemang will come forward and present this brief.

---EXHIBIT NO. 361: Submission of the Society of Obstetricians and Gynaecologists of Toronto.



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Mr. Chairman, is that of the Society of Obstetricians and
Gynaecologists of Toronto, which will be known as Exhibit
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SUBMISSION OF
THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF TORONTO

APPEARANCES:

DR. W. H. ALLEMANG

DR. ALLEMANG: Mr. Chairman, Members of the Commission, I would ask your indulgence and my apologies if there are infringements and overlapping in respect to these presentations.

Ours is an extremely brief presentation, having cognizance of the major presentation from the Canadian Society, the more generic group. The Toronto Society of Obstetricians and Gynaecologists is presently composed of about 87 members. New members total about, approximately, 100 that are in prospect. All of these are certified in obstetrics and gynaecology, or hold their fellowship in the Royal College of Physicians and Surgeons of Canada.

They are members of sixteen hospitals in Metropolitan Toronto and these hospitals consist of five university hospitals associated with the Faculty of Medicine, University of Toronto and eleven non-university hospitals. The purpose of this Society is very much like the previous Society: To consider those problems of particular interest to the specialty within the Metropolitan Area of Toronto and to investigate and present findings relative to these problems.

In so doing, it hopes to unite members



APPENDIX:

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Allemand 12217

of this specialty of the University and non-university hospital services and the members of this Society, as you may well recognize, are also members of the Provincial Section of the specialty, as well as the Canadian Society and the Royal College.

With this brief preamble, I would like to proceed to the summary and these, as I stated originally, are areas that we thought might not be covered. To obtain this information I personally, as Chairman of the Committee within this Society made a survey of general hospitals in Toronto, Metropolitan Toronto and we received replies from this survey from 12 out of the 16; five university hospitals submitted theirs and 11 non-university hospitals.

To show the scope and magnitude of all admissions of obstetrics and gynaecology, we find that in the year 1961, or 1960, as the case of two hospitals, total hospital admissions for that year in these 12 hospitals were 165,000. Of these 53,900 were obstetrical and gynaecological cases. That is, approximately one-third of the admissions to hospital fall within the scope of this specialty. There were 33,000 obstetric deliveries, approximately one-fifth of all admissions.



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THE CHAIRMAN: Would that correspond to live births?

DR. ALLEMANG: Yes, this is an approximation.

THE CHAIRMAN: Are the two synonymous in that respect?

DR. ALLEMANG: Not necessarily. I don't know, this is an approximation. There are very few non-live births, so that it makes very little difference.

This essentially means that if a patient is admitted to these general hospitals, one in five takes a baby home with them.

For an excellent teaching service at both the undergraduate and post-graduate level, public cases are vital. While some of these might be lost in a comprehensive prepaid medical scheme for teaching purposes ---

THE CHAIRMAN: On that point, you have had three years, and you are going into your fourth year, of experience in Toronto in prepaid hospitalization?

DR. ALLEMANG: Yes.

THE CHAIRMAN: Have you found any experience in that period worthwhile that you can comment on?

DR. ALLEMANG: Our public service, on the whole, has been well-maintained. There has been no falling off in our public service because of prepaid hospital services.

THE CHAIRMAN: Do you sense any



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reluctance on the part of any patients to participate in the teaching program or to be taught upon?

DR. ALLEMANG: In general, no, sir. There are individual exceptions, of course.

THE CHAIRMAN: I suppose they existed before?

DR. ALLEMANG: Yes.

THE CHAIRMAN: You see, this is an apprehension that has been expressed very broadly across the country. You are now, as I say, you are into your fourth year of experience in Toronto, and your experience here, your view may be quite important on this point.

DR. ALLEMANG: Well, our experience to date is that prepaid hospital insurance has made no decline in our public patients.

THE CHAIRMAN: Why then do you appear to fear that the prepaid medical would have a different effect?

DR. ALLEMANG: I am not saying that I fear it, sir. I am saying that it may have that effect.

THE CHAIRMAN: Well, I added the word fear, you see.

DR. ALLEMANG: Yes. We find that since the war that our public services have been largely supported through new Canadians, recent arrivals, who have been accustomed to this type of service where they came from. I am sure our public services would have declined significantly if we hadn't had the influx of immigrants. We find that with these people they aspire,



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just as we do, to a better standard, and I don't know, but I suspect that if they were covered for medical services that many of them would seek out a private doctor. I am not saying that this is wrong, but I think that a number would.

THE CHAIRMAN: Well, it couldn't be wrong. It is a most expected-to-happen situation.

DR. ALLEMANG: It is a very natural sequence. However, I would go on to say this loss might be offset by improved personal services. Here is the big point: people, by and large, still expect quality and if we can offer them the quality of service that they recognize we should be able to, I don't think that we need have any major fears for our future.

One may say that the medical service that is offered on our public current services is of the very highest order, and undoubtedly, for the seriously ill patient, represents the finest care that can be obtained.

Now, I would much rather be a seriously ill patient in our public service than on a private service, because you have the opportunity of teamwork and consultation, which is vital and cannot be obtained from any private service.

COMMISSIONER BALTZAN: Why can't you achieve that?

DR. ALLEMANG: I am talking about a minority of cases.

THE CHAIRMAN: You are talking about in the natural order of the day-to-day operation in the

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Allemang 12221

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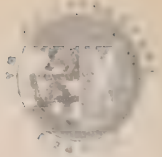
DR. ALLEMANG: Yes. I am not talking in this case about cases other than that are seriously and desperately ill. These require round-the-clock care, continuous therapy, and efforts on behalf of a number of teams. We will find these patients on our service.

A man admitted with severe shock, blood pressure zero, who is going to lose kidney function and his life unless he is well-supported over the next few days, or a week perhaps, and this requires very intensive and careful care. Not only we must see them, medical consultants must see them ---

COMMISSIONER BALTZAN: I am just exploring when I put that question to you. In that same regard, couldn't you have that same teamwork with your interns, residents and assistants, not being available constantly, and will your staff not continue the same organization of total care in any well-departmentalized hospital?

DR. ALLEMANG: Yes, this can be given in any particular type of unit, providing you have the set-up and the organization to do it, but I would say that currently, on our public services at the university hospitals, this is set up in relation to them.

Now, there is no reason why it couldn't be broadly set up and in respect to patients the same teamwork will apply, but I think that most of us with a seriously ill patient would put them in the intensive therapy unit in the type of service we call public at the present.



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Actually, at the Toronto General Hospital, in the new building, there is very little difference existing between standard ward or public care and private patients.

THE CHAIRMAN: That is a developing trend?

DR. ALLEMANG: Yes. The accommodation in hospital is the same. Our delivery rooms and our labour rooms, our obstetric floor, is common to both groups. Even the meals are the same. The decorations in the room are the same. The same staff looks after public and private patients. So there is a diminishing difference really.

The medical service offered these patients is of the highest order.

33% of private obstetric cases were attended by specialists, but from a consideration of the necessity for specialist care, as evidenced by obstetrical complications, only 15% of obstetric cases fell into this group. Thus, the desire for specialist obstetric care appeared to be more than twice its necessity.

The reasons for this are probably rather obstruse, and I don't know if they are relevant to this particular discussion, but twice as many patients accept obstetric care as needed.

THE CHAIRMAN: Well, I suppose they want the best.

DR. ALLEMANG: In view of the services required in obstetric care in the pre-natal and post-natal



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period as well as during labour and delivery, it is felt that present obstetrical fees allowed by present prepaid medical insurance schemes are too low in comparison with other surgical fees.

Members of this Society have recently unanimously rejected a closed contract agreement for specialists' services because it lacked a differential fee schedule that did not take into consideration the variations in local costs of practice, varying difficulties in individual cases and experience and skill of the attending physician.

In short, this is a field that is very complex, and is quite a stickler with the medical profession, and it would appear that this is a field in which some conscientious thought and application would have to be applied to make a comprehensive prepaid scheme palatable to all groups within the framework of the medical profession.

And lastly, and this is perhaps one of the more important aspects of this small brief, modern statistical procedures in tabulating and processing medical conditions, their treatment and their results, are lacking and should be instituted and standardized on a provincial and national basis.

THE CHAIRMAN: Coming back to this matter which you referred to, as it might appear to be an over-demand for specialist services; it has been suggested that if everybody could be sure that there were going to be no complications, they could take a chance on almost anyone, but in this service complications



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Allemang

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dollarise and may arise and perhaps dollarise very suddenly, and it is a matter of preparedness as much as anything else, so that you cannot, in a sense, blame the public for the demand if it looks like a legitimate demand on the part of the public.

DR. ALLEMANG: It is, in essence, a form of insurance.

THE CHAIRMAN: Yes. Your last paragraph: we have run into this matter of deficiency in health indices and apart from anything else we are trying to work out with the Bureau of Statistics and the Department of National Health and Welfare what might be a new procedure in statistical returns and compilations in the Dominion Bureau of Statistics.

It is not really part of our business, but we got involved in it, and, at our suggestion, they have taken up the idea and are going forward with it.

DR. ALLEMANG: I might, if I may say so, sir, that it is extremely important to us who are involved in hospital care programs and management, and particularly in university services with respect to research. We should know what is passing through our hands, what we are dealing with, and what our results are.

I think it is quite amazing to us that this has not been standardized in some continuing fashion up until now.

THE CHAIRMAN: All we can say for the moment is that some thought is being given to it by those whose business it is to deal with statistical

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information and procedures of that kind. Dr. Baltzan?

COMMISSIONER BALTZAN: I have exhausted my knowledge of obstetrics and gynaecology. I have no questions.

THE CHAIRMAN: Dr. Van Wart?

COMMISSIONER VAN WART: I never had any, so I have no questions.

THE CHAIRMAN: Well, I think, Dr. Allemang, you have added, this has been additional to the other and the sum total becomes pretty important by the time we are through with these hearings, and the further information that is in the brief. All of this will go to our medical education project initially and back to us ultimately with a final report. Thank you very much.



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Allemang

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THE SECRETARY: Mr. Chairman, the next submission is that of the Canadian Association of Pathologists, and it will be known as Exhibit No. 362, and Dr. Pritzker will introduce his group.

--- EXHIBIT NO. 362: Submission of the Canadian Association of Pathologists.

SUBMISSION OF THE CANADIAN ASSOCIATION
OF PATHOLOGISTS.

Appearances: Dr. F.W. Wiglesworth
Dr. D.W. Penner
Dr. H.G. Pritzker

DR. PRITZKER: Mr. Chairman, the gentleman on my right is Dr. Wiglesworth, the President of the Canadian Association of Pathologists and pathologist at the Children's Hospital in Montreal and my colleague to the left is Dr. Penner, the pathologist at the Winnipeg General Hospital and the Secretary-Treasurer of our Association.

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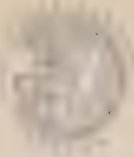
DR. PRITZKER: Sir, would it be in order if I read the summary and conclusions of our brief?

THE CHAIRMAN: Very much so.

DR. PRITZKER: Mr. Chairman and Members of the Commission:
1. The Canadian Association of Pathologists recognizes its responsibility for the maintenance and expansion of medical laboratory services. It is actively concerned in the education of pathologists and technologists, in the development and expansion of laboratory services, and in the rigid control of quality in laboratory medicine.

2. Pathology is that branch of medicine which treats of the essential nature of disease, particularly of the structural and functional changes in the organs and tissues of the body which cause or are caused by disease. In this presentation, "pathology" is used synonymously with "clinical pathology" and includes those branches of medicine commonly practiced in the laboratory, viz: gross and microscopic pathology, hematology, serology, cytology, blood banking, chemical pathology (biochemistry), bacteriology, virology and parasitology.

3. The pathologist is a duly licensed medical practitioner who possesses a recognized qualification in the specialty (commonly Certification in Pathology by The Royal College of Physicians and Surgeons of Canada, or an accepted equivalent). As a physician, he is subject to the same privileges and



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5 tions, as are all physicians. His practice is almost
6 entirely a "referred" one. Basically a request for a
7 laboratory examination is a request for a consultation
8 from one physician to another.

9 4. (a) Pathology is a specialty of
10 medicine and a part of medical patient care. It should
11 be so classified and remunerated regardless of the
12 paying agency, if there be one.

13 (b) Pathologists, as practicing
14 physicians, subscribe to the fourteen principles of the
15 Canadian Medical Association concerning medical service
16 insurance.

17 5. The constantly increasing demand for
18 pathology services is likely to continue. Additional
19 increased utilization of laboratory services, as by
20 non-hospital patients, without prior provision for
21 expansion of medical and technical personnel, equipment
22 and housing, can only lead to deterioration in quality
23 and inferior service to the public.

24 6. In an expansion of laboratory services
25 the following principles must be maintained:-

26 (a) The laboratory rendering diagnostic
27 service must be under the direction of
28 a pathologist.

29 (b) General laboratory services, and
30 the services of pathologists, should
be made available in smaller hospitals
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specialized or rare investigations, is not appropriate for the majority of diagnostic laboratory procedures.

(c) No plea for rapid expansion of services can be allowed to compromise the quality of the individual service. Quality control of laboratory work is essential for proper patient care.

Mr. Chairman, if I might read the conclusions from the brief, some of which I am afraid overlap the summary. They are as follows.

1. The Canadian Association of Pathologists has always recognized the responsibility for the maintenance and expansion of medical laboratory services.

It has been actively concerned in the education of pathologists and technologists, in the development of laboratory services and in the rigid control of quality in laboratory work.

2. Pathology is a specialty of medicine and a part of medical patient care. It must be so classified and remunerated regardless of the paying agency.

If pathological services are to be continued to be paid for under the aegis of the Hospital Insurance and Diagnostic Services Act, then that Act must be amended so that these services are paid for separately and distinctly from hospital services.

The pathologists, as practicing physicians, subscribe fully to the fourteen principles of the Canadian Medical Association concerning medical service insurance.



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3. The present tempo of expansion of pathology services is not likely to lessen. Any broadening in the availability of laboratory diagnostic services to out-patients will markedly increase the speed of expansion.

4. In an expansion of laboratory services the following principles must be maintained:

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(b) General laboratory services, and the services of pathologists should be made available in smaller hospitals and centres. Centralization, while useful for unusually difficult, specialized, or rare investigations is not appropriate for the majority of diagnostic laboratory work.

(c) No plea for rapid expansion of services can be allowed to compromise the quality of the individual service. Quality control of laboratory work is essential for proper patient care.

It should never be forgotten that quality of laboratory work along with quantity requires adequate staffing and space. Thank you.

THE CHAIRMAN: Thank you, Dr. Pritzker.

You are making a suggestion in the conclusion, page 17, that if the pathological services

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4 are to be continued to be paid for under The Hospital
5 Insurance and Diagnostic Services Act, that the act be
6 amended. Why do you say that? Why the necessity for
7 that? Initially it may appear to be a matter of
8 administrative arrangement.

9 DR. PRITZKER: Yes. We welcome the
10 opportunity of amplifying that statement, Mr. Chairman,
11 and perhaps I can illustrate it best by citing a rather
12 homely example.

13 We feel that if all of the hospital
14 services and our pathology services are to be paid for
15 as a unit, as they are now, there comes a time when the
16 director of the laboratory will, for example, present
17 to the administrator his ---

18 THE CHAIRMAN: His budget?

19 DR. PRITZKER: His budget, and other
20 parts of the hospital, not related at all, also present
21 their needs; the administrator of the hospital is going
22 to get so much money, and it then becomes a problem
23 for the administrator, a decision has to be made, for
24 example, say the engagement of more cleaners, or
25 technicians. We feel that the medical care part of this
26 program should be considered in an entirely different
27 light, even budget-wise, than the hospital care. I
28 think we are talking about two different things, even
29 though they may be happening in the same institution,
30 under the same roof.

THE CHAIRMAN: The present system is
that it is the province which determines what the
operation in any given hospital is, and after that is



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4 determined, depending on the formula for the individual
5 province, basically it is 50-50, the Dominion Government
6 then sends a cheque and is totally unconcerned where
7 that money goes, because it goes to the province, it
8 is actually given to the province and if pathology was
9 taken out, then one would run the risk of not getting
the 50%.

10 DR. PENNER: As I understand it, sir,
11 that is the practical application right now; in other
12 words, the hospital as it is set up does not provide
13 for medical professional services as such, and if these
14 were set out under the present Act that is what it would
15 mean, these funds would not be available. Right now
16 in many of the labs across Canada where the budgets
17 have been getting tighter and the problem of providing
18 increasing funds for the hospital has rapidly expanded
19 and increased, the demand to hold the line, which might
20 be quite economically justified, creates a problem if
the demands for more hospital and medical care services
are there.

21 In my own hospital we are finding
22 we were asked to keep the budget within one or two per-
23 cent of the last year, the work in my lab went up 25%.
24 This has presented a great problem to the administration
25 and to me in trying to run the lab. Other areas have
26 also increased, but perhaps not to the same extent, and
27 I find that I am harking with the administrator on the
28 justification of me getting an increase of 25%. We have
29 the cleaners who want a wage increase or some other
30 area rather unrelated directly to the provision of



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8 THE CHAIRMAN: That is what we heard
9 in Alberta, it is this freezing of the budget that was
10 causing the trouble. Not only had Saskatchewan and
11 Manitoba the 3%, Alberta loosened up to six recently,
12 some time ago.

13 DR. PENNER: In labs across the country
14 this 25% is not at all unusual in many of the areas, and
15 and is not 25% from any given base line but from the
16 previous year.

17 THE CHAIRMAN: Is not the devil of the
18 piece here this matter of freezing budgets?

19 DR. PENNER: It becomes the practical
20 problem of the administrator, that is right.

21 THE CHAIRMAN: Of government having
22 frozen hospital budgets?

23 DR. PENNER: Yes.

24 THE CHAIRMAN: And that is an inevitable
25 consequence, result of a state-operated system in health
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THE CHAIRMAN: That is what we heard in Alberta, it is this freezing of the budget that was causing the trouble. Not only had Saskatchewan and Manitoba the 3%, Alberta frozen up to six recently,

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MR. PERNER: In fact across the country this 3% is not at all unusual in many of the areas, and and is not 2% from any given base line but from the previous year.

THE CHAIRMAN: Is not the devil of the piece here this matter of freezing budgets?

MR. PERNER: It becomes the practical problem of the administrator, that is right.

THE CHAIRMAN: Of government paying frozen hospital budgets?

THE CHAIRMAN: And that is an inevitable consequence, result of a state-operated system in health services, or in anything else?



Wiglesworth 12234

dpw DR. WIGLESWORTH: This, of course, makes it very difficult to get adequate qualitative control. It seems to me that for the non-laboratory men, both professional and layman, it is very difficult to understand that a laboratory, while it may be called scientific, depends a great deal on experience and personnel. It is not like inorganic chemistry where everything is cut and dried, it is a science in a way but it requires personal experience, it requires equipment and the quality; if we have too much quantity it goes down rapidly because we have to do these things rapidly and when this happens the quality must go down because the technicians are rushed, they have to do so many tests and they become less accurate because they are pushed.

This problem of the budget business; it is a natural tendency to be economical but we know what we want, what we need, certain equipment, and we should have it.

THE CHAIRMAN: Is putting it into a separate budget going to accomplish that?

DR. PRITZKER: We feel that people who handle budgets would look a little differently at this matter if they saw this part of the money is for medical care and this part is for other attributes of hospital service.

THE CHAIRMAN: Quite frankly - I have the experience of being the Chairman of the Board of a hospital and we make up a budget and there is a whole page for the pathological department, X dollars. When



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but it is almost a separate page. What would be the
difference if we had it in a different book?

DR. PRITZKER: Your experience may be
a little different than ours. We get the impression,
rightly or wrongly, that sometimes there is a great
deal of sympathy expressed for workloads and the fact
we need more people but there is not enough money for
it. We feel this should be looked at differently.

It is true it is all dollars but one part really does
involve a very serious aspect of the patient, namely,
medical care, and one part may be something a little
less important.

We are not trying to infer that shelter
and looking after cleanliness are not important things
but that is our impression. We feel very strongly that
the inhibitions, shall we put it that way, the budgetary
inhibitions that may exist for economic reasons, should
not be so stringently applied to the medical care as to
other areas.

THE CHAIRMAN: I think everyone would
readily accept your suggestion or proposition but does
it have any more strength merely because it is separated?

DR. PRITZKER: We also feel it is this
service that puts a little different connotation on
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We feel it deserves a type of consideration because, after all, it happens to be a medical service within a hospital.

THE CHAIRMAN: Are there any other similar services now? I know radiology used to be but I do not think it is any more but anything that is the same as pathology in the hospital?

DR. PRITZKER: The radiological services would be the closest, I cannot think of any other diagnostic services per se. I think we have to stick to that. I am not thinking of pathology as an all-embracing thing.

DR. WIGLESWORTH: It seems to me, in many provinces, that we have seen expressed where the administrator has taken the money, they get the lumped budget and the administrator has the control to shift the budget to what they consider the more pressing needs and this has created a very serious disturbance in many provinces.

It seems to me the administration, the administrator, who may not be a doctor, may have the power, when he gets a lump budget, to readjust the points he thinks are more urgent, which we may not consider equally as urgent.

THE CHAIRMAN: So you want the money earmarked?

DR. PENNER: We feel it would help for a better quality of care. As Dr. Pritzker said, I think the public at large does not appreciate that a laboratory

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DR. PENNER: We feel it would help for a better quality of care. As Dr. Britner said, I think the public at large does not appreciate that a laboratory



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test improperly done is perhaps worse than no test at all. They look at it just like reading something in the newspaper; it is accurate because it comes from the laboratory. However, you would know and Dr. Baltzan would know that there are all qualities of lab reports.

Sometimes it might cost a person's life to be cut short or it may lead to a series of expenses for years of treatment and so on, and we feel very strongly that the quality which can be so difficult to maintain may be one of the things which is less appreciated and we feel this would be, if it were separated out, possibly from different administrative channels and looked at differently, it would be easier to get this point across and to maintain this level.

Obviously, with my budget being stuck at 1% increase and a volume of 25% increase, the question is: how do you operate? It is sort of ambiguous.

The point is, we operated by putting in overtime, by everybody rushing a little more and inevitably losing some of the quality because there is no other way of doing it. There comes a level, if you drop below, then probably it will be better if you did not do it at all.

THE CHAIRMAN: I think we understand your position.

COMMISSIONER VAN WART: On page 1, the second paragraph, you point out what pathology in the lab consists of and you mention chemical pathology; that is biochemistry. The persons in charge of this section of your laboratory; are they trained biochemists?



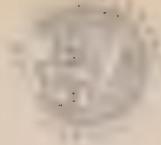
Pritzker 12238

DR. PRITZKER: In many instances the overall charge is in the hands of pathologists who have taken, in their post-graduate work, some biochemistry. As you know, to get certification today, one must spend at least a year in so-called clinical pathology. Some of the larger laboratories, the people that are directly in charge of this biochemistry department, may be specially qualified physicians who are devoting a lifetime to biochemistry; in some cases, what we call medical laboratory scientists, M.A.'s and Ph.D.'s or Doctors of Science.

COMMISSIONER VAN WART: And your training as pathologists; you say you are required to have one year of training in the clinical chemistry in the lab. We received a brief from the Society of Clinical Chemists requesting that they be separated from the Department of Pathology, that they have a separate branch like x-ray, etc. Have you any opinion on that?

DR. WIGLESWORTH: The Ph.D. and M.A. or M.Sc., is a professional man in his own right, he has the details and knowledge of chemistry which the pathologist has not got. But, the pathologist has had training in medicine, he has had an overall training in laboratory procedures, whether it is tissue diagnosis, hematology, bacteriology, and he has an idea of the human body as well which the chemist has not.

Now, the M.Sc. or Ph.D. is capable of running a laboratory and running it beautifully and practically and directing it and ordering supplies, but



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when it comes to clinical interpretation - supposing a physician comes in and says, "What does this mean?" and the chemist can only say it is a blood sugar that is higher than it should be.

The pathologist, with his proper training, may be able to give the physician some idea what it may mean. The biochemist can, perhaps, learn some of that after years of experience and contact with physicians but he is not an M.D. and should, in that respect, have no connection with medical care; that is, consultation on patients and things like that. Otherwise he is perfectly capable of running a biochemistry lab.

COMMISSIONER VAN WART: They designated themselves as clinical chemists and I believe there were some medical men among them.

DR. WIGLESWORTH: About 15 M.D. medical chemists are in the country and they belong to the Society of Medical Chemists.

COMMISSIONER VAN WART: And these men would have the experience you are speaking of?

DR. WIGLESWORTH: I think so. I am not certain but they are most valuable. The point has come that we have to use, because of the small number of pathologists related to population, because of the increase in laboratory activities, we have to have people who are trained as specialists in the scientific aspects of these groups and they are invaluable. In fact, at Laval, they are going to start a course to train biochemists, M.Sc. Ph.D. grades for hospital work



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in order to fill these tremendous gaps that are occurring in such hospital laboratories as biochemistry.

THE CHAIRMAN: They were saying that they should have one of these clinical chemists for every 300 beds in the hospital.

DR. WIGLESWORTH: Probably, yes.

THE CHAIRMAN: Hospitals of 300 beds and then with the larger ones they would need more.

DR. WIGLESWORTH: I believe that is correct. The pathologist is the overseer in a sense and on individual details - for instance, chemical tests are always going wrong - not always going wrong but frequently they do and it takes time to pick them up and if there is a trained man in charge of the lab he can pick it up much more quickly and leave the pathologist free to direct the whole set-up of the laboratory services in the hospital.

COMMISSIONER VAN WART: The same thing would be true of the bacteriologist and the other branches you mention?

DR. PRITZKER: It would not be right for us to leave the wrong impression. The ideal situation would be if we had enough fully-trained clinical pathologists who can man all these different aspects of the situation.

DR. PENNER: In the large institutions we tend to have medical bacteriologists and medical pathologists who can act as medical consultants. We feel this, of all things, is our greatest contribution, to take the obviously mechanical scientific tests and

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apply them to the patient for their treatment and care. This is where our function is at its greatest value and where most of these people, by reason of their training and experience are not capable of taking over.

COMMISSIONER STRACHAN: They are doctors even though they are not physicians? Many of them, I think, are?

DR. PENNER: Many of them are doctors but not of medicine.

COMMISSIONER VAN WART: Turning to page 2, on the same line, you speak of the deterioration of quality, inferior service to the public and so on, by virtue of not enough staff. That does not mean directors like yourselves in pathology but you mean more your technicians and your clinical biochemists and bacteriologists and so on? Is that where the shortage is or is it in the top?

DR. PENNER: Both.

DR. WIGLESWORTH: A pathologist, if he is directing a department, has to take care of the administration. He may be taking tissue diagnosis; tissue diagnosis is something that needs experience and with a pathologist who is fatigued with these other matters, he can only do so much microscopic work before he begins missing things which he should not miss. That is where the director gets the fatigue, these other things. Tissue diagnosis is semi-scientific; in a way it requires a great deal of experience and time and thought to spend on the tissue slides and if there are problems from other areas and fatigue, the quality in that area will drop because he cannot do it; he can only do so much



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per day.

COMMISSIONER VAN WART: I notice you mention nothing about research. Has research been going on?

DR. PENNER: Page 9, education and research. We did not put that in our summary. We obviously wanted to keep the summary brief, but of course there has been continual research of both the practical research to apply and develop new tests and procedures as they come along which is the day to day bread and butter type of thing. Then there is the more fundamental type of research, more in relation to the type of research that is more basic and not practical application in hospitals, depending on the size. Even the smallest hospital has to have this one phase of developmental research. One might not even call this research, although in a sense it is.

In the larger hospitals, of course, much of the research in Canada traditionally has been going on in these areas. It only recently has been expanded into special research areas, and so on. Up until very recently the bulk of the research has been done in the larger teaching university hospitals and still has a very important and a very heavy part of the research.

COMMISSIONER VAN WART: Shortage of funds for research?

DR. PENNER: Particularly the shortage of skilled people, both technical and professional. Shortage of funds really exist in the precariousness of the funds really often more than the actual available dollars.

In other words you do not see a future in it because it is a day to day, year to year grant. It



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3 is not a very good prospect for young people going into
4 it. We have shortages, very definitely, both at the
5 medical level and at the technical level.

6 THE CHAIRMAN: Thank you very much
7 gentlemen.

8 DR. PENNER: Thank you sir.

9 DR. PRITZKER: It is our pleasure to
10 have been here.

11 THE SECRETARY: Our next submission,
12 Mr. Chairman, will be that of the Canadian Society of
13 Laboratory Technologists and will be known as exhibit 363.
14 Mr. Shearer will present this brief.

15 ---EXHIBIT NO. 363:

Submission of the Canadian
Society of Laboratory
Technologists.



SUBMISSION OF
CANADIAN SOCIETY OF LABORATORY TECHNOLOGISTS

APPEARANCES:

Mr. B.F. Wood
Mr. R.N. Uttley

MR. WOOD: Mr. Chairman, this is Mr. Uttley. Mr. Shearer was to have presented this brief but he could not be with us today. Mr. Uttley is a highly qualified technologist. I am not but he can answer any technical questions you may care to ask.

THE CHAIRMAN: Just take a chair Mr. Wood please.

MR. WOOD: May I proceed.

THE CHAIRMAN: If you will.

MR. WOOD: I was advised by your Secretary sir that this brief may be taken as read. In the few minutes allowed to us I shall only enlarge briefly upon the recommendations made in the introduction to our submission.

The Canadian Society of Laboratory Technologists was incorporated under Dominion Charter in 1937 for the following purposes and objects namely:

- "To improve the qualifications and
- "standing of Laboratory technicians
- "in Canada; to promote research endeavour
- "in all branches of laboratory work;
- "to promote a recognized and professional
- "status for technicians; to promote
- "closer co-operation between the
- "medical profession and the technician;

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"status for technicians; to promote

"closer co-operation between the

"medical profession and the technician;



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"to more efficiently aid in diagnosing
"and treating disease.

"The operation of the Corporation is
"to be carried on throughout the
"Dominion of Canada and elsewhere."

Acting under this authority the C.S.L.T.
has established the "R.T." as the standard of qualifica-
tion for the practice of medical laboratory technology
which is recognized across Canada; it has maintained
the Register of medical laboratory technologists in
Canada; it has issued certificates of qualifications
based on examinations which it has conducted uniformly
across Canada; these examinations have been based upon
a syllabus prepared by the Society and revised by it
from time to time.

The Canadian Society of Laboratory
Technologists is affiliated with the Canadian Medical
Association and the Canadian Hospital Association and works
closely with the Canadian Association of Pathologists.
There are in Canada more than 120 centres in which
medical technologists may be trained. These include
universities, colleges, provincial laboratories,
technological institutes and hospital laboratories.
All of these training centres have been approved by the
C.M.A. Committee on Approval of training for medical
laboratory technologists.

In our recommendations, it will be
noted that the first recommendation reads as follows:

"It should be mandatory that all
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"medical technology be certified as
"qualified for registration as medical
"technologists."

You will have noted from the Brief presented to you a very short time ago by the Canadian Association of Pathologists that there is in Canada a tremendous shortage of qualified medical technologists. It may seem incongruous that we should make this recommendation while this shortage exists, but in view of the ever increasing importance of medical technology in the diagnosis of disease, it is our belief that only fully qualified personnel, who have been so certified, should be permitted to engage in the practice of medical technology. This does not mean that at the present time that everyone employed in a hospital laboratory must necessarily be qualified for registration. In the larger hospital laboratories, which are usually highly departmentalized, some of the routine tasks are performed by lesser qualified personnel but they should not be classified as medical technologists and should in all cases be supervised by qualified personnel.

THE CHAIRMAN: Qualified personnel being pathologists or others?

MR. WOOD: In the smaller hospitals sir, there is not always pathologists in attendance.

THE CHAIRMAN: Always in attendance.

MR. WOOD: They should at least be supervised by qualified medical technologists.

In the smaller laboratories, however, particularly where a pathologist is not in regular



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THE CHAIRMAN: Always in attendance.

MR. WOOD: They should at least be

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4 attendance, it should be mandatory that only well
5 qualified personnel be employed, since the responsibility
6 for the administration, organization and performance
7 rests with them. In this respect the standards of
8 certification developed by the C.S.L.T. serve as a
9 criterion of acceptability.

10 In view of the very serious shortage
11 of qualified medical technologists in Canada it is
12 obvious that adequate facilities must be provided for
13 the training of students in this profession. At the
14 present time more than 90% of the registered technologists
15 in Canada are women. Our statistics show that the
16 average time spent in the profession by women is
17 approximately two years. The Canadian Medical Association
18 has recommended that the training period for medical
19 technologists should be at least 18 months and preferably
20 two years. If, therefore, the present facilities are not
21 expanded it means that we are only training enough
22 technologists to meet our annual depletion and are not
23 training in sufficient numbers to meet the ever
24 increasing demand for medical technologists. One obvious
25 solution, as the Canadian Association of Pathologists
26 have pointed out in their Brief, is to make the profession
27 of medical technology sufficiently attractive to encourage
28 more men to choose this profession as a lifetime career.
29 You may be interested in learning that in most areas
30 in Canada there is no dearth of applicants for training
in this profession. As a matter of fact, for most of
the better courses in different provinces, more than two
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attendance, it should be mandatory that only well-qualified personnel be employed, since the responsibility for the administration, organization and performance rests with them. In this respect the standards of certification developed by the C.S.I.T. serve as a criterion of responsibility.

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You may be interested in learning that in most areas in Canada there is no dearth of applicants for training in this profession. As a matter of fact, for most of the better courses in different provinces, more than one third of the applicants must be rejected for lack of



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training facilities.

THE CHAIRMAN: No dearth of male applicants?

MR. WOOD: No, of applicants.

THE CHAIRMAN: What about male applicants?

MR. WOOD: We are getting more men within the last year. Up until a year or so ago most high school students appeared to think that medical technology was a woman's profession. In the Provincial laboratory here in Ontario, for example, over half of their last class is male.

THE CHAIRMAN: What is the basic educational qualifications?

MR. WOOD: Senior matriculation sir, including -- and that is complete senior matriculation including two mathematics and two sciences, one of which must be chemistry.

In the last few years, there has been a tendency toward regional centralized training where space, facilities, equipment and personnel may be provided without disrupting the necessary routine of the hospital laboratory.

THE CHAIRMAN: Before you go to that, the training is in-service training is it?

MR. WOOD: Well there are four or five different types of training in Canada now sir. There are two universities, the University of Saskatchewan and the University of Alberta that give degree courses in medical technology. Regina College



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4 which is now the south campus, I believe of the University
5 of Saskatchewan gives a very fine two-year course in
6 medical technology. Laval University ---

7 THE CHAIRMAN: They will have started
8 this Fall on the second year.

9 MR. WOOD: Yes. Laval University
10 gives a course of one academic year at its University of
11 Montreal. All of these university courses must be
12 followed, of course, by practical training in a hospital.

13 There are some hospital laboratories
14 which give a very fine course. The first six months
15 is a didactic course of lectures, combined with
16 laboratory, followed by practical experience.

17 The Provincial laboratory give a
18 didactic course and then send their people out to an
19 approved hospital and laboratory and there are still some
20 hospitals, quite a large number in fact, where the
21 training is all practical training, apprenticeship
22 type of training for a period of approximately two years.

23 COMMISSIONER BALTZAN: Do these
24 people then qualify for examination in your organization?

25 MR. WOOD: Yes sir. At the completion
26 of their course they are qualified to write our
27 examinations.

28 COMMISSIONER BALTZAN: And these
29 hospitals that do that are recognized as preparatory
30 teaching hospitals?

MR. WOOD: They are approved hospital
laboratories for that purpose, sir. One of the basis
of approval -- the basis of approval is the appendix to



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our brief but you note that one of the bases is that they must have at least 200 general beds before they can qualify as a training institute.

THE CHAIRMAN: Thank you.

MR. WOOD: In some cases this centralized training is provided by hospitals which pool their resources to provide the necessary facilities and instructors. Usually in these cases, the first six months of the training is given in a central location under the direction of qualified instructor giving lectures and supplementary laboratory exercises. Following this initial period of training, the students are usually returned to their hospital laboratories for 12 months of practical experience. Following this second phase of training, these students are eligible to write the C.S.L.T. examinations for certification as registered technologists.

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One of these centralized programs is located in Hamilton. They take the facilities of the Mountain Sanatorium, and all the approved laboratories in that area send their students for training under full-time qualified instructors. Then they are returned for practical experience for twelve months.

In a number of provinces in Canada, the new technological institutes have inaugurated courses in medical technology in cooperation with the hospitals in the area. In such cases, the hospitals recruit the students and send them to these institutes for their initial phase of training. Following this training, which is usually for a period of six months, the students are returned to their respective hospitals for a further period of training of approximately 12 months.

Although these various types of centralized training will undoubtedly result in an output of better qualified technologists, they may not alleviate the present shortage in the profession, because the intake of students is limited by the capacity of the hospitals to provide this second phase of training. It would appear, therefore, that the only solution would be to provide additional training facilities where students could complete their entire period of training without interrupting the routine of hospital laboratories.

The C.S.L.T. has recently inaugurated advanced classes of certification namely, Advanced Registered Technologist and Licentiate. To qualify for these levels of certification, our members must not only have spent many years in the practice of their profession,



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but also must undertake post-graduate courses and pass qualifying examinations. In order that more of our members may qualify for advanced levels of certification, our Society has recommended to hospitals, universities and other training institutions, that they give advanced training courses to registered technologists who wish to keep abreast with developments in their profession. We are also endeavouring to encourage more university graduates with degrees in the biological sciences to enter the profession of medical technology, but if this is to be done, the profession should be made sufficiently attractive to encourage people with these qualifications to choose this profession as a lifetime career.

Mr. Chairman, that is all I wish to add to our brief. We shall be glad to answer any questions that you might care to put to us.

THE CHAIRMAN: Mr. Uttley, do you wish to add something?

MR. UTTLEY: No, Mr. Wood has covered it very, very thoroughly. I think it boils down to the fact that we need added facilities for training technologists. That is our big drawback right now. There are few places we can go even to get advanced training, and this brief I think pretty well describes the reasons for that.

THE CHAIRMAN: Now, without appearing to be facetious, we have the matter of basic training. What is the urgency of advanced training in that sense?

MR. UTTLEY: Well, it is a very rapidly advancing field in lab work.

but also must undertake post-graduate courses and pass
qualifying examinations. In order that more of our
members may qualify for advanced levels of certification,
our Society has recommended to hospitals, universities and
other training institutions, that they give advanced
training courses to registered technologists who wish to
keep abreast with developments in their profession. We
are also endeavouring to encourage more university
graduates with degrees in the biological sciences to
enter the profession of medical technology, but if this
is to be done, the profession should be made sufficiently
attractive to encourage people with these qualifications
to choose this profession as a lifetime career.

Mr. Chairman, that is all I wish to

add to our brief. We shall be glad to answer any
questions that you might care to put to us.

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MR. UTTLEY: Well, it is a very rapidly
advancing field in lab work.



Uttley 12253

THE CHAIRMAN: An expanding field?

MR. UTTLEY: Expanding, yes.

For instance, I myself in Toronto last week was working on a test at the Toronto General Hospital. We have no other place to go, and there are so few places we can get that type of training.

THE CHAIRMAN: Yes, this is additional training. It may not be in the sense --- perhaps I misunderstood you, the way you put it and the way it was put originally. Not that you put it incorrectly, I merely didn't appreciate it correctly. The basic appeal, or lack of appeal to your male applicants must be a question of salary, I suppose?

MR. UTTLEY: It used to be monetary originally I know. That was the very big problem. That has been getting better as time goes along, and now we are attracting more male technicians.

THE CHAIRMAN: Because the salary situation has righted itself somewhat?

MR. UTTLEY: A great deal.

MR. WOOD: Our salary problem now is not so much the starting salary for registered technologists. It is the salary for the people at the very senior levels.

COMMISSIONER VAN WART: Do you find that industry is draining off technologists from hospital services and so on, on account of salary, and the research departments of drug companies and so on?

MR. WOOD: We have a constant demand from the various drug companies, which we cannot fill. In fact, we cannot fill our own demands. We have in our



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MR. UTILEY: Expanding, yes.

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In fact, we cannot fill our own demands. We have in our



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little employment office in Hamilton over 150 vacancies at the present time which we cannot fill. A large number of technologists have been brought from other countries. In fact some of the hospitals have gone to Europe to recruit. A lot of them have come from the United Kingdom. A number recently came from South Africa. And a number from Central Europe. After the Hungarian Revolution a number of technologists came to Canada, and found employment, and the standards, I must say, in Europe, where they have similar societies, and there is an international association, the standards are very good.

THE CHAIRMAN: This is perhaps not too relevant, but we hear from you, and from practically every organization that has come before us, emphasizing the lack, the shortage of personnel and as you say now, the matter of payment of the initial salary is not too bad. This is what we hear, and yet we hear that there are thousands of unemployed. Why don't some of those people who are out of work find their way into these areas where there are such tremendous shortages, and which is, by and large, a pretty nice kind of work? Is it a matter of lack of recruitment? Is it passing them by, or do they lack the basic educational requirements, or something?

MR. UTTLEY: They likely lack the educational requirements, I would say. Grade XIII, Senior Matriculation is quite high, but we need that calibre of person in this profession.

THE CHAIRMAN: Yes, I think we would accept that unhesitatingly.

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MR. UTILITY: They likely lack the educational requirements, I would say. The X-ray technician is quite high, but we need that caliber of person in this profession.

THE CHAIRMAN: Yes, I think we would accept that unhesitatingly.



Wood 12255

COMMISSIONER STRACHAN: Could there not be another element here, the vocational guidance in high school tends almost always towards university education. Are the high school graduates being made aware of such vocations as this?

MR. WOOD: Yes, they are. We have three times as many applicants as we can accept. Our main problem now is lack of training facilities.

THE CHAIRMAN: That is very good. That is the answer to that one for the moment.

MR. WOOD: We think that the only solution may be to have separate training institutions, where they can train right through, including the year of practical experience, because the hospitals can only accept so many students in their laboratories for that year of practical training.

THE CHAIRMAN: How would they get that year of practical training? Would they go to commercial firms? If they cannot go to the hospital labs for it, where would they get it?

MR. WOOD: It might be in these technological institutes that they could put in the laboratories and get their specimens from hospitals in the area, and give the practical year's training there. Dr. Young in the Toronto General Hospital is instituting something of that nature. He is in the fortunate position of having his training laboratory entirely separate from his other laboratories, and also he is in the fortunate position where he can get the specimens immediately, so he is hoping, instead of putting the



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students in the training laboratory for six months, to give the whole 18 months in the training laboratory.

THE CHAIRMAN: We had a private individual before us here last week, of a private commercial laboratory. Where do they fit into the picture? Are their technicians members of your Society?

MR. UTTLEY: Yes, I think a number of those people working in the lab, and the Director of that place is a member of our Society.

THE CHAIRMAN: He told us there were several others in the City?

MR. UTTLEY: Yes, every larger city has a private lab of that nature, and I know numbers of our fellow members are in that field.

THE CHAIRMAN: I know in Regina there appears to be what I might call a co-op, what they call the Regina Medical Laboratories. It is a private affair.

MR. UTTLEY: Does not it have to be under the direction of a medical doctor? I think it has to be here.

THE CHAIRMAN: I was just wondering. You go to the doctor's office, and whatever examination, tissue or blood, it is made in what appears to be a separate institution. And you get a bill from this separate institution.

MR. WOOD: We have one of those private laboratories in Hamilton in the Medical Arts Building.

THE CHAIRMAN: This is actually in the Medical Arts Building in Regina.

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throughout the country. They are not supposed to accept people off the street. They only are supposed to perform the tests requested by the doctor, and they are to be referred to the laboratories by the doctor, and the report goes back to the doctor. Our members cannot make any diagnosis whatsoever. They can only report to the pathologist, or the physician in charge.

COMMISSIONER GIRARD: On Page 6 you say in Paragraph 4, inadequacies of present training programs. It appears that the trainees of the hospital schools and the provincial laboratories have an unduly high failure rate in their training. Does this mean that they are lost to the profession, or do they take the exams over, and why are these schools permitted to continue if they do not seem to be doing a good job?

MR. WOOD: To answer your first question, they may have have two supplementaries, and if they pass those supplementaries they may obtain their registration.

To answer your second question, the C.M.A. Committee on Approvals is at the present time reviewing all the approved hospital laboratories.

I attended a meeting two or three weeks ago. A number were rejected. A number were put on probation. In a number of instances the period of training was only twelve months. They have now insisted that there be at least 18 months, and preferably two years, and I think that will improve the training.

In a number of the hospital laboratories, where they train only one or two students, there was no



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But that doesn't mean that in all the hospital laboratories they don't get this training. In Toronto General, Vancouver General, Hamilton St. Joseph's, Hamilton General, they do give them didactic training before they put them in the various departments and boards.

COMMISSIONER GIRARD: Do you have any standards for the lab of the hospitals that do have schools? Do you have any minimum standards?

MR. WOOD: Yes, we do. You will find that in Appendix 3 in the brief, basis of approval.

COMMISSIONER GIRARD: Do you feel, by eliminating the schools where the labs are for only a few students, you would correct this unduly high rate of failures?

MR. WOOD: Yes. Some of the schools are giving up because of the high rate of failures; they haven't the staff to give these lectures.

COMMISSIONER BALTZAN: Gentlemen, do you find that all the recognized hospitals would be willing and anxious to accept more students if they had the accommodation and if they had the necessary allowances in order to carry these students through?

MR. WOOD: I think so, sir; although at the present time we have no training in English in Montreal and the hospitals there, the larger English-speaking hospitals, don't seem very desirous of undertaking this training.

COMMISSIONER BALTZAN: Why?

MR. WOOD: I think they are training

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their own people to their own standards.

THE CHAIRMAN: And that is why you have your first recommendation here, that it is mandatory that they do have the certification in the Association?

MR. UTTLEY: It would improve standards if that were so.

COMMISSIONER BALTZAN: I have no other questions. Thank you very much. I understand your problem.

THE CHAIRMAN: Thank you very much, gentlemen.



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THE CHAIRMAN: Thank you very much.

Gentlemen.



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THE SECRETARY: Mr. Chairman, if I may, I have been advised by Mr. Rodgers of the Metropolitan General Hospital in Windsor, Ontario, by a letter dated May 29th, that it will be impossible for either he or Mr. Buckner, their Hospital Administrator, to attend the Commission's hearings tomorrow, and I would like permission to put this letter into the record of the Commission today.

Dear Sir:-

The writer was scheduled to appear before the Commission on Friday, June 1st, 1962, at 5.00 p.m. to present a verbal submission to the Commission in the areas mentioned in your letter of March 13th, 1962. Unfortunately, Mr. Robert Buckner, the Hospital Administrator, was admitted to the hospital on Saturday, May 26th with a recurrence of a heart condition which he has had for the past five years and it will be impossible for the writer to attend in person.

We respectfully request that the following information which we would have preferred to present in person be read into the record of the Commission.

The Commission have requested information from the hospital on the following items:-

- (a) The use of hospital beds.
- (b) The length of stay of patients.
- (c) Waiting periods until admission.
- (d) Beds not used for various reasons.
- (e) Any other relevant information on the subject of making the most effective



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and efficient use of hospital facilities, beds, operating rooms, diagnostic services, etc.

(f) By what proportion the daily patient census can be reduced if adequate alternative facilities and services were available, e.g. chronic, convalescent and rehabilitation facilities; homes for the aged and home care programs.

(a) The use of hospital beds. Metropolitan General Hospital has a rated capacity of 356 adult and children's beds and 46 newborn bassinets. The actual number of beds permanently set up for adults and children is 362.

The breakdown of adult and patients' beds by classification is:

240 Medical-Surgical

38 Obstetric

30 Psychiatric

45 Paediatric

9 Communicable Diseases

The percentage of occupancy by classification for the year 1961 was as follows:

Medical-Surgical	95%
Obstetric	83%
Paediatric	80%
Psychiatric	86%
Communicable Diseases	34%

The percentage of occupancy for all beds



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The percentage of occupancy by classifica-

cation for the year 1961 was as follows:

Obstetric 83%

Paediatric 86%

Psychiatric 88%

Communicable Diseases 94%

The percentage of occupancy for all beds



for the year 1961 was 91%.

(b) The length of stay of patients.

The Ontario Hospital Services Commission's Annual Report for 1960 indicates the average length of stay for Group B Hospitals was nine days. Metropolitan General Hospital's average length of stay was ten compared to the provincial average of nine and the Windsor area average of 8.7.

We feel that this is accounted for by the fact that we operate a Psychiatric Unit in this hospital and the average length of stay for patients on the Psychiatric Unit is double that of a Medical-Surgical Ward. Also, at this hospital we treat large numbers of cancer patients, perhaps because the Windsor Clinic of the Ontario Cancer Treatment and Research Foundation is housed in our hospital and this type of patient usually has a longer stay than other patients.

Another factor which contributes to the higher average days' stay at this hospital is the shortage of chronic beds in the Windsor area. This opinion is supported by evidence of waiting periods of from six weeks to two months for patients at this hospital to gain admission to the chronic hospital.

(c) Waiting periods until admission.

Generally the waiting period for elective surgery is six weeks.

There is also a waiting period for medical cases and this list averages forty in number. It is difficult to give an accurate figure on the length of the waiting period for medical cases but it is not

for the year 1961 was 31%.

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unusual to have some of the less urgent cases waiting for periods of over one month.

(d) Beds not used for various reasons.

There are several reasons why hospital beds may be vacant and cannot be used and they are as follows:-

(a) Because of the patient's sex,

(b) Because a bed is on a specific service, for example, psychiatry or

paediatrics,

(c) Because of repairs or maintenance to the room, and

(d) Because of construction.

(e) Any other relevant information on the subject of making the most effective and efficient use of hospital facilities, beds, operating rooms, diagnostic services, etc.

The recent Amendment to the Ontario Hospital Services Commission Act extending the coverage for outpatient services will eventually relieve the bed situation at this hospital to some extent as soon as we have taken steps to provide the facilities for these outpatients. This will also make more efficient use of our operating rooms which, for the most part, are used only between the hours of 7.00 a.m. and 1.00 p.m., Monday through Friday.

As far as the diagnostic services at this hospital is concerned, we feel that they are being used effectively and efficiently at the present time as we have always had a large volume of outpatients treated in our Diagnostic Services Departments.

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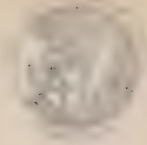
patient census can be reduced if adequate alternative facilities and services were available, e.g. chronic, convalescent and rehabilitation facilities, homes for the aged and home care programs. We would estimate that on the average we have from twenty-five to fifty patients who could be treated in a chronic or a convalescent hospital if this type of facility were available.

At the request of our Medical Staff in September of 1959, we engaged a Medical Social Worker at this hospital to assist Doctors and Hospital Administration to transfer patients who no longer required general hospital care to either a chronic hospital, a nursing home, or a home for the aged.

We believe that the addition of this type of professional person to the hospital team has been of great benefit in moving patients from general hospital beds to a type of institution in which the patient requires less professional care.

Once again we wish to express our apologies to the Commission for not being able to appear in person but, under the circumstances, we find it impossible.

Signed. James B. Rodgers,
Assistant Administrator.



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Signed, James B. Rogers,



THE SECRETARY: Mr. Chairman, the next submission is the Canadian Mothercraft Society. It will be Exhibit 364, and Mrs. Hewitt will speak to the brief.

--- EXHIBIT NO. 364: Submission of the Canadian Mothercraft Society.

SUBMISSION OF THE CANADIAN MOTHERCRAFT
SOCIETY.

Appearances: Miss E.M. Hewitt
Mrs. Mona Gould

MISS HEWITT: Mr. Chairman, I would like to introduce Mrs. Mona Gould, who is our Public Relations Officer, from Toronto.

The Mothercraft Society is probably really unique in that simply we are a health organization; we do no nursing of the sick at all and our work is entirely from the health point of view. We have two main services. One is to maintain a hospital for babies who are not organically ill but who have training problems; the mother losing sleep, and so on, and where the mother is ill.

I am from Ottawa and after I sent in the brief I realized that the recommendations I made should have been in the brief, but I have them here.

COMMISSIONER GIRARD: If you don't mind, I may ask for any explanation as you go along.

When you say you have hospitals, what hospitals are these?

MISS HEWITT: We just have the one

next submission is the Canadian Mothercraft Society.
It will be Exhibit 364, and Mrs. Hewitt will speak
to the brief.

--- EXHIBIT No. 364: Submission of the Canadian
Mothercraft Society.

SUBMISSION OF THE CANADIAN MOTHERCRAFT

Apparances: Miss E.M. Hewitt
Mrs. Mona Gould

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mind, I may ask for any explanation as you go along.

When you say you have hospitals, what

hospitals are these?

MISS HEWITT: We just have the one



Hewitt

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hospital here in Toronto.

COMMISSIONER GIRARD: Yes; when I was a student in Toronto I remember hearing about it.

MISS HEWITT: We are, of course, part of this chain, which was started in New Zealand, and the students that we train, some of them are previously untrained students. Now we have trained around 600.

COMMISSIONER GIRARD: In this mothercraft hospital you have a school?

MISS HEWITT: Yes. It is actually more of a training school, but so that the nurses have the material, we do admit these patients, and one is a mother who is trying to breast-feed her baby.

COMMISSIONER GIRARD: Any mother who has a baby and which would not be a medical problem?

MISS HEWITT: Yes.

COMMISSIONER GIRARD: I am trying to make the analogy. We have, in Montreal, what we call the Creche.

MISS HEWITT: It was one of the points I am trying to bring out here, that in visiting the mothercraft centres in New Zealand I found there that the district nurses had the opportunity, if they come across a tired mother in the home, they say, "You need a rest. We will send a housekeeper into the home."

Now, we have these nurses on our registry in Ottawa and three calls in succession came to me to send a nurse into the home where the mother had a nervous breakdown, and I just wondered if the mother had been put into this hospital, or a rest home, whether it

hospital here in Toronto.

COMMISSIONER GIBBARD: Yes; when I was

a student in Toronto I remember hearing about it.

MISS HEWITT: Yes, of course, that

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the students that we train, some of them are previously

untrained students. Now we have trained around 800.

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Hewitt

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would have avoided this complete nervous breakdown, with five little children.

I sent one of our nurses into that home, and we keep on impressing on mothers the fact that the happiness of the home depends so much on the mother's health, and that is why we have the training for the mothers.

That was another recommendation I was going to make, that all mothers, if possible, should have education for childbirth. We notice the difference where the mother has taken the time, and I think the doctors should recommend this, they should say, especially to the mother having her first baby: "I want you to come along and learn about births." I think the mother should have the education, and that is one of the recommendations I would like to make.

I know, from our experience, we have pre-natal classes, that is one part of our work, admitting babies who have breast-feeding problems and training if the mothers are ill, and we have trained around 600 students.

I think we have run into a little difficulty, of course, with the classification of nurses. These nurses, we call them well-baby nurses, they go into the home and help the mother when she comes home from hospital with a new baby. Now, we do attract a very fine type of student.

THE CHAIRMAN: Where do these students come from? High school?

MISS HEWITT: They come from high school.



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into the home and help the mother when she comes home

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very fine type of student.

THE CHAIRMAN: Where do these students

come from? High schools?

MISS HEWITT: They come from high school



Hewitt

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We quite often attract the student who is not too good academically at school. I have spoken at various high schools in Ottawa, where they have got to maybe the third grade, they are perhaps lagging a bit, and with the counsellors they could get this training.

COMMISSIONER GIRARD: Do you have any students who have failed academically who seem to have the knack for this?

MRS. GOULD: Not too many. It is the other way around.

COMMISSIONER GIRARD: I have had a number take this training because they had a certain personality but not able to cope with the academic work.

MISS HEWITT: Yes, just a little bit below the standard for the academic. But we have trained students right across Canada, from every province. The mothercraft training centre is the only centre of this particular kind where we admit the mothers with their babies.

THE CHAIRMAN: You say 600?

MISS HEWITT: Yes.

THE CHAIRMAN: Over what period?

MISS HEWITT: The Mothercraft was established in Canada in 1931, so it is over 30 years.

THE CHAIRMAN: Now, you are training how many?

MISS HEWITT: At present we have 26 students in training. We run around anywhere from 20 to 25.



Hewitt

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THE CHAIRMAN: But only in this one area, in Ottawa?

MISS HEWITT: The only training centre is here in Toronto. We think that not only is this a training which gives the girl a profession to carry on her bent, if she feels like being a baby nurse, certified nurse - of course, most of our students get married; we have a very small number left on our registry because they have married. We think the training helps in that they pass on their training.

COMMISSIONER GIRARD: Are your certified students, once they are certified, employed in the nurseries in general hospitals?

MISS HEWITT: They are not. Just the last, maybe, 10 years, hospitals have been very glad to get them. But, you see, they have to be what is known as uncertified nursing assistants. These students don't want to nurse the sick. Our students want to nurse babies, they want to be in the home, and it is this longing to do this. It is one year's complete training and our students pay \$300 to take this training.

Now, it doesn't pay us to train these students, \$300 with board, and so on, it doesn't begin to pay it, but we believe so much in these students and the good work they are doing, and we continue to train them at a financial loss.



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M/hm

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4 THE CHAIRMAN: But afterwards, if
5 they do not get married and that sort of thing, do they
6 go out to be governesses or that kind of thing? Is there
7 any place in society for them?

8 MR. HEWITT: We have registries in
9 both Ottawa and Toronto where we send them out into the
10 homes when the mother comes home with the new baby.
11 They have no trouble getting positions and we hate to
12 say it but we even lost several of them to Hollywood.
13 We train them to be of help in Canadian families but,
14 unfortunately, they have an appeal in other parts of
15 the country, they are in the United States and in England
16 and other countries.

17 One of the recommendations too we have
18 besides training these students, we have prenatal
19 classes. The registered nurses, of course, do the
20 prenatal classes. One of the recommendations, of course,
21 is that we would like to see a relaxation on hospital
22 rules and regulations, that we feel these rigid rules
23 for the trained parents -- I know some do not want such
24 a thing but others want to be together when the child
25 is born. We happen to have some very fine people who
26 believe childbirth is a family affair and are very keen
27 to be together through this whole thing. We would like
28 to make a recommendation that the hospital rules be
29 relaxed for these people who are trained.

30 COMMISSIONER GIRARD: I am all for it,
I think they should be there.

MISS HEWITT: The mother wants to be
conscious, we are not suggesting she should not take

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3 anaesthetic but the mother wishes it, she wants to be
4 conscious and when she is trained she does a particularly
5 fine job. I have kept track of 1,001 mothers that have
6 gone through the schools and I have always asked a
7 mother who has had babies both ways, anaesthetized and
8 conscious participation, I have asked them which they
9 would rather have and I have never met one that said
10 they would want the anaesthetic again. They seem to think
11 this is something they would have not missed. This
12 is one of the things we feel very sad about. I have
13 one or two letters from mothers, the mothers all send
14 me back a letter and tell me what happened with them
15 after they have had the baby. This one mother said she
16 was with her husband in the corridor of the hospital
17 because there was no room set aside for the husbands and
18 wives. The husband could support his wife during this
19 important event, they want their husbands there. In
20 greater Philadelphia -- by the way, there is an inter-
21 national childbirth association and this is their bulletin
22 and they mention five years ago there was just one
23 hospital in Philadelphia that permitted husbands in the
24 delivery room; one year ago there were eight and today
25 there are twelve. As you can see, there is a step in
26 this direction.

27 What we are finding in Ottawa -- I
28 had hoped to hear one baby before we left, she is simply
29 staying home to have her baby because she wants to have
30 her husband with her.

We would like to make a recommendation
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Hewitt

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4 that this could be permitted. We have Dr. Robert Bradley
5 from Vancouver Memorial speaking this month and he has
6 spent nine years conducting prenatal classes. He has
7 had husbands in the delivery room there with a very,
8 very happy result, it just could not be happier. We met
9 one, the mother is a registered nurse in Canada and,
10 as a matter of fact, they walked out of the hospital
11 with the baby in their arms when it was two hours old.
12 That seems a little far fetched but they are very fine
13 people.

14 Then another mother, from one of these
15 letters, she was 50 hours in labour and alone a great
16 deal of the time and the husband was at home pacing up
17 and down. How much better it would have been if he had
18 been there. She ends up by saying that the next time
19 they hope to be together. Those are some of the letters
20 I received and those are things that I would like very
21 much to see changed if at all possible. I do not know
22 how we can work on the hospitals but I am a great believer
23 in changes.

24 Another recommendation I feel very
25 keenly about is the value of registered nurse mid-wives.
26 I put in my brief that Canada is the only country of
27 a comparable type of country that has no training for
28 registered nurse mid-wives.

29 THE CHAIRMAN: We have some in Alberta.

30 MISS HEWITT: I think something similar
but in Canada mid-wifery is a bad word and why I do not
know. There is no group of nurses that have as high
standards in any country and I have travelled in a few of



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Hewitt

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4 them, New Zealand, Australia, Great Britain. I am a
5 Canadian trained nurse and I went to England back in
6 1937 to take a year's mid-wifery training. I must confess
7 I was not even interested in taking it, I asked for
8 leave of absence from Mothercraft and was told I could
9 go if I would take this mid-wifery training and I did
10 because I thought it would keep me in London for a year.
11 I was really terribly impressed with the understanding
12 of these trained people. You cannot in any wildest
13 moment compare them with -- I am not saying anything
14 disparaging in any way about Canadian training -- we
15 cannot compare three months, and I think I am right,
16 I do not think any nurses training, obstetrical training
17 in Canada is longer than three months, so we cannot
18 compare with a whole year's training, two years in some
19 countries but mostly one year where a registered nurse
20 takes a specialized course in obstetrical care.

18 THE CHAIRMAN: You see, your submission
19 is quite relevant in the light of what we have been
20 told about the shortage of medical practitioners,
21 general practitioners and particularly in the more
22 outlying areas.

23 MISS HEWITT: I would like to table
24 this "Do we need mid-wives in Canada".

25 COMMISSIONER GIRARD: May I say that
26 this would be very nice if some nurses could take mid-
27 wifery but not all nurses because we would be wasting
28 time there because of the situation in Canada. Deliveries
29 in Canada are made by doctors and it is different in
30 England where they expect the mid-wife to make all the



them, New Zealand, Australia, Great Britain. I am a Canadian trained nurse and I went to England last 1937 to take a year's mid-wifery training. I must confess I was not even interested in taking it, I asked for leave of absence from Methodist and was told I could do if I would take this mid-wifery training and I did because I thought it would keep me in London for a year. I was really terribly impressed with the understanding of these trained people. You cannot in any way compare them with -- I am not saying anything disparaging in any way about Canadian training -- we cannot compare three months, and I think I am right, I do not think any nurse training, obstetrical training in Canada is longer than three months, so we cannot compare with a whole year's training, two years in some count has not mostly one year where a registered nurse takes a specialized course in obstetrical cases.

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MISS HENRY: I would like to table this "Do we need midwives in Canada". COMMISSIONER HENRY: May I say that this would be very nice if some nurses could take the mid-wifery but not all nurses because we would be using time there because of the situation in Canada. It is different in Canada and made by doctors and it is different in England where they expect the midwife to make all the



Hewitt

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4 deliveries except those that are not normal. If we can
5 at least get the nurses that are going to work in out-
6 posts and in the northern territories, all those that
7 are going to have to do that, they should at least have
8 mid-wifery. However, I do not think that we should
9 recommend it for all. I am sure you understand that.

10 MISS HEWITT: In these other countries
11 you can be a registered nurse without any obstetrical
12 training at all, if you are registered as a nurse you
13 are going to do children's nursing, do theatre and
14 operating work, work you do not need it but any nurse
15 doing maternal and child welfare of any description,
16 supervising of the obstetrical floor, doing Queen's
17 nursing, R.V.O.N. nursing, they would all have this one
18 year's training in mid-wifery.

19 THE CHAIRMAN: So, having no school
20 to train them in Canada we could subsidize and have
21 the training done in England?

22 MISS HEWITT: To me, I do not feel very
23 happy that Canadian nurses have to go out of our country
24 to get such a training. When I did my mid-wifery in
25 England there was a Canadian nurse who came from Alberta
26 and she had been working 50 miles from a doctor, up in
27 one of these out-posts in Canada. She told me frankly
28 that she paid her own way -- I was paid to take the
29 training and my fee was taken care of but she paid her
30 own fee and lost a year's time because she said she felt
insecure. She was 50 miles from a doctor and she felt
insecure. I have a great appreciation for our nurse's
training in Canada and the fact this nurse felt this



Hewitt

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3 insecurity, that her training did not give her what she
4 wanted that she had to go to England. There are six
5 mid-wifery training schools in the United States and
6 they are liked very, very much and I think Canada
7 patterns herself after the United States quite a bit.
8 I have articles here by the Maternity Centre Association
9 in New York and they also bring out the fact of the value
10 of the nurse mid-wife, the shortage of doctors. Not that
11 the nurse mid-wife is supplanting the doctor in any way
12 but she is part of a team, shall we say, it is a team.

13 There would be no such thing as
14 interfering with the performance if a doctor is not
15 present, where you have your own trained nurse mid-wife,
16 they are trained to deliver a normal child. They are
17 able to recognize the abnormalities and I feel when I
18 came back that the mothers were in the hands of these
19 trained people who had dealt with the normal and did a
20 wonderful job and were trained to recognize any
21 abnormalities and get help for the mothers.

22 THE CHAIRMAN: That help in England
23 is nearby?

24 MISS HEWITT: Yes.

25 THE CHAIRMAN: What would be the
26 situation here where help is 50 to 100 miles away?

27 MISS HEWITT: Our whole set-up would
28 have to change. Of course, these other countries that
29 have so many home deliveries, I have had doctors asking
30 about this home delivery many, many times. I always
come back to the fact -- I know statistics are uninteresting
things to quote but, nevertheless, in the countries where

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THE CHAIRMAN: That helps in England.

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Hewitt

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3 there are home deliveries, where there are highly
4 qualified nurse mid-wives, the mortality rates are very
5 favourable.

6 THE CHAIRMAN: This afternoon we had
7 two organizations before us and they were urging more
8 deliveries in hospitals.

9 MISS HEWITT: Well, I have worked with
10 these mothers who tried this whole thing and it was so
11 normal, I have had several mothers and, do you know a
12 rather interesting thing, it is the highly educated mother
13 that wants to be at home, she wants to be conscious of
14 doing something that is new and that is going to be a
15 good thing for the family. They want to be home and
16 together at this important time, therefore, if they
17 cannot get it in hospitals then, as I say, they are
18 turning their thoughts to "Shall we have a home delivery?"
19 We did have one brave doctor near Ottawa in a little
20 hospital who got two fathers into the delivery room
21 but the medical profession clamped down -- he got two
22 of them in but they said "No". There was no reason
23 for it, nobody fainted but nevertheless, they must not
24 do it again.

25 Another recommendation we would very
26 much like to make is the question of rooming in for the
27 baby. I made a note of this in my brief that Dr.
28 Bolby said that this separating of the mother and baby
29 right after birth was not the best way to have the best
30 family relationship because then the baby is a total
stranger to the mother when she goes home with it.
Now, again, one of our hospitals in Ottawa did allow



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Hewitt

12278

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3
4 rooming in; this mother said she did not want to go to
5 a hospital, she would like to be at home and have her
6 baby with her, she did not want to be separated from her
7 baby. The doctor asked one of the supervisors and she
8 said they had been wanting to try it and they did try
9 it and everybody agreed it worked however, would they
allow another mother to do it? No, it was off the books.

10 COMMISSIONER GIRARD: When the rooming
11 in first came out, it originated at Yale Grace Hospital,
12 everybody was for rooming in. However, I understand
13 now, even in the United States where everyone was for
14 it, that they are beginning to get away from it. There
15 is the feeling now that the mother needs some rest and
16 she is going to take care of her baby when she goes
17 back home so she needs the rest now. For some mothers
18 it is good but for others they should have the rest
19 while they are in the hospital and the nurses are going
20 to rely on the mother to look after the baby if the
baby is in the room with her so there are a series of
different theories.

21 THE CHAIRMAN: Out west we used to
22 say it was the mother's annual holiday.

23 COMMISSIONER GIRARD: They are not
24 so keen on it in the United States as they were about
25 ten years ago.

26 MISS HEWITT: I think maybe if it
27 could be elastic, I do not know if that is possible
28 because some mothers maybe do not want it, do not want
29 their babies in the room but many, many do and I think
30 it could be worked. Here is a mother who wants rooming

rooming in; this mother said she did not want to go to a hospital, she would like to be at home and have her baby with her, she did not want to be separated from her baby. The doctor asked one of the nurses and she said they had been wanting to try it and they did try it and everybody agreed it worked however, would they

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THE CHAIRMAN: Our next we need to say it was the mother's mind, right?

to keep on it in the United States as they were about ten years ago.

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Hewitt

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4 in -- I often feel these things are a mental block we
5 put up. One of the arguments against it is that you
6 need so much equipment. Well, to me to move a baby into
7 a mother's room I cannot believe there is a lot of
8 equipment needed in such a case as that.

9 COMMISSIONER GIRARD: The hospital has
10 to be built for it, it is difficult in the old hospitals
11 but when you are building a new hospital, some of them
12 even have this drawer kind of thing where the baby can
13 be passed from one side to the other.

14 -

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be passed from one side to the other.



Hewitt 12280

MISS HEWITT: That is right. You can make it complicated or you can make it simple.

The other point is I do feel very keenly about the lack of --- the small number of, shall we say, breast-fed babies. I think again our rooming-in would help in this situation very much. I have a letter from a mother --- this also was a baby born just about a month ago --- and she said that she had a very happy time at the birth. She was conscious and saw the baby born through the mirrors. Everything was fine. I was appalled to learn, she said, my baby was the only breast-fed baby in the nursery of some 36 babies.

Now I wonder just what is the fault in this situation? This is a general situation. Whether again, this comes from hospitals, doctors, nurses. If they are all to blame, but certainly I think the first step -- I was reading about the brief submitted by the emotionally disturbed children, and it seems to me that the first step in this happy relationship in building the best nervous system in a child is the mother to nurse her baby, breast-feed her baby. That closeness to the baby surely will build a good nervous system starting right from the very beginning. We do deplore this very much.

I think education is the answer. I think the mother needs to be educated but she also needs encouragement in our hospitals. Some mothers are keen enough about it. They will go through any difficulties. Other mothers do need help and need encouragement. One of the harms, of course, about rooming-in is the infection.



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Other mothers do need help and need encouragement. And

of the nurses, of course, about nursing is the relation



Hewitt 12281

Some hospitals have had to decentralize their babies because of infections, but I do not think that the infections when there is not a large number of babies together --- I think you will find that infection is not one of the things we need to worry too much about. Those are just some thoughts that I had.

COMMISSIONER VAN WART: How is your society financed?

MISS HEWITT: By faith. We have mothers who simply believe enough in the work they support it where they go about having all sorts of affairs for raising funds. We do have fees. For instance, mothers pay \$10.00 to come to the prenatal classes but that only brings in a small revenue because we trained over, between Ottawa and Toronto, 250 -- some number like that of mothers in prenatal care.

One thing in Mothercraft work, there is a continuity we enjoy. The same nurse that has the mothers coming prenataally also has those mothers returning for supervision, the ones who wish to come back and have their babies checked and weighed and they appreciate, as they call it, continuity; that the same person that knew them during the prenatal period is also the one that sees the small baby and guides the family, becomes a sort of counsellor, not only for the small children, but we get into our teenagers, and so on. You become a friend of the whole family and in this way they get to know you too. Financing comes in that way, but in our hospital, our hospital, of course, there are fees that come in for the patient and we have been receiving a grant



Lewitt 12281

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Hewitt 12282

just for the patients, the number of patient beds, same as any hospital.

COMMISSONER VAN WART: Under the Ontario Hospital Plan?

MISS HEWITT: We are not registered now as a hospital. It's more of a training school, which has made it a little more difficult in the financing.

COMMISSIONER VAN WART: Your grant comes from ---

MISS HEWITT: The Ontario Government.

COMMISSIONER VAN WART: Directly?

MISS HEWITT: Directly from the Ontario Government, and we get the rate for the patients that are admitted there. We get the grant from the Government for that.

The nurses pay this \$300.00 fee, as I say. It doesn't pay us to train them, but it all helps, and we get to wondering each year how we are going to keep in the black. Somehow or other, we do seem to manage. It certainly is difficult.

Another recommendation we would very much like to make is the hospitalization of sick children is very close to us. Not that we have too many. We have tried to teach our mothers in the facts of health. Nevertheless, children take sick and then we would like to see a little relaxation of the visiting for parents of these children.

I think since we deal with the problems when the child comes out of the hospital and when it seems to take us more than a month to see this little child who



11/1/52

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to take a long time to see this little child who



Hewitt

12283

has been hospitalized get over the trauma that he suffered, I do feel that when the parents are allowed to visit with almost unlimited time it would be a great advantage to these little children.

I think that is another recommendation I would like to make.

It was Dr. Thomas from McGill University that mentioned, again in a little brief put out by the Maternity Centre in New York, and he again mentioned the value of the need of the nurse midwife. That the shortage of doctors is going to create quite a problem. Here is some way that the mothers are going to be able to receive the adequate help and not overload the doctors. They would help us with the mothers. That is one complaint mothers have made repeatedly, that they are left alone in labour and I think again, of course, where the nurse midwife is trained in that, she would have an opportunity of being with the mothers with the training she has. Be a great support for the mother.

It is rather interesting, there are groups forming not only just in one isolated place, but they are forming across the country. I mentioned this International Child Birth Education. Also in Chicago there is a group for encouraging the breast-feeding, what they call the LaLeche League, and this group of mothers banded themselves together to encourage other mothers to breast-feed the babies. Now, they meet in each others' homes. There must be almost 50 of them throughout the States. They meet in the homes.

Just going over the various points



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Newton

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 Just going over the various points



Hewitt

12284

relating to the breast-feeding, successful breast-feeding, and again I think it's the lay people that are taking a sort of lead in this.. This is something they wish and this is something that they really want and they are taking the lead in it.

I would be very happy if I can just table those that might be of interest.

THE CHAIRMAN: We would be very pleased to have anything you wish to table. Mr. Lafrance will take it.

MISS HEWITT: Fine, thank you.

THE CHAIRMAN: So that we will have it in the record and get it back to your office in Ottawa.

MISS HEWITT: Mr. Lafrance knows I am in Ottawa. Maybe it will come back to me there. I don't know now that there are any other points.

I think that the one thing I would like to say is if we can get over what I call the mental block to some of these problems. I think instead of putting up the difficulties if people would realize that they can more or less banish a lot of these difficulties that we have. The problems of getting the husbands in the delivery room. I don't think it is much of a problem. It's just again a question of changing policies and routines and getting people to see the picture and the hospitals to serve the mothers in the way, within reason, in the way they would like and this is one thing, of course, that we had so many requests for.

COMMISSIONER GIRARD: I don't see why we couldn't put a white gown and boots and a mask on every



Hewitt 12285

husband and let him into the delivery room.

MISS HEWITT: That is right. I think one of the things -- Dr. Hillary when he was climbing -- the mother who wants to be conscious at the birth of her baby --- it was Dr. Atlee from Halifax, Dalhousie University, he said in regard to the mother who wants to be conscious during the birth it was like Hillary climbing the Himalayas and just as he got up to the peak, he was getting pretty tired at this point, and somebody said to him, you are very tired, just better take something to block this out, and he would miss that tremendous exhilaration that came with reaching the peak and Dr. Atlee likened this to the mothers who want to be conscious and I think, you see, if we had our nurse midwife in the hospital supporting these mothers that they would obtain the type of help that they would like and would remember with great happiness, I would think.

Mrs. Bamford and Mrs. Ruddell are here. Mrs. Bamford is one of our nurses who took our training a few years ago. She is now the mother of five children, and can now speak from her own experience.

THE CHAIRMAN: Thank you very much, Miss Hewitt. This has been a most pleasant discussion, and a little bit out of the ordinary run of the mill that we have been listening to. It has been put in such a friendly way at the end of this long day, it was refreshing rather than anything else.

MISS HEWITT: I must say I have enjoyed it too. I have been giving a little bit of thought to it and just one other point that came to me. One thing

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MISS HEWITT: That is right. I think

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DR. BARNARD and Mrs. Barnard are here

Mrs. Barnard is one of our nurses who took and training a

few years ago. She is now one of the best of five children,

and can now speak from her own experience.

THE CHAIRMAN: Thank you very much.

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ROYAL COMMISSION ON

Hewitt 12286

we deplore very much are the giving of sedatives to small babies. I think again where your mother is trained and the mother is breast-feeding her baby, I think that has cut down tremendously on the amount of drugs that are being given to babies.

I don't know about Toronto, but it seems it is routine in Ottawa. The mother gets a prescription before she ever leaves the hospital and this is a little distressing to mothers who don't really want to use drugs. They don't believe in them and they feel they should have them, so I think again where the mother is trained we will get away from that.

COMMISSIONER BALTZAN: Very excellent thoughts on it.

MISS HEWITT: Thank you very much.

COMMISSIONER BALTZAN: I personally appreciated listening to you in a very personal way. It was rather novel and interesting to me especially never having had a daughter, or any daughters, never had a sister, to introduce me to the other phase of the problem.

MISS HEWITT: Thank you very much. I have enjoyed it too.

THE CHAIRMAN: We will now rise until nine o'clock tomorrow morning.

---Adjournment.

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MISS HEWITT: Thank you very much. I

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nine o'clock tomorrow morning.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

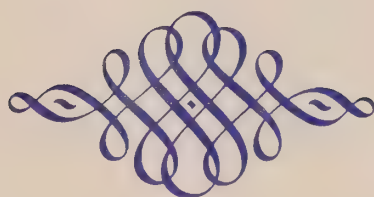
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THE ONTARIO ASSOCIATION OF MEDICAL
CLINICS

THE CANADIAN PODIATRY ASSOCIATION
& THE ONTARIO PODIATRY ASSOCIATION

THE INTERPROVINCIAL ASSOCIATION OF
PROSTHETISTS AND ORTHOTISTS OF
CANADA

MRS. A. KENNEDY

CITIZENS' HEALTH ASSOCIATION

DR. J.W. McGLIVRAY

ST. MICHAEL'S HOSPITAL

SARINIA GENERAL HOSPITAL

THE TORONTO GENERAL HOSPITAL



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VOLUME 65

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings
held in Toronto, Ontario,
on the 1st day of June, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O.J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE

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DR. DAVID M. BALTZAN

COMMISSION COUNSELLORS:

MR. R. H. HALL, O.C.

DIRECTOR OF RESEARCH:

MR. N. LAFRANCE



---On resuming at 9:00 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning will be from the Ontario Association of Medical Clinics and it will be exhibit 365, and Dr. Strashin will introduce his group and speak to the brief.

---EXHIBIT NO. 365: Submission of the Ontario Association of Medical Clinics.

SUBMISSION OF
THE ONTARIO ASSOCIATION OF MEDICAL CLINICS

APPEARANCES:

Dr. I. Strashin
Mr. A.B. McFarlane
Dr. J. Patterson
Mr. G.R. Wildblood

DR. STRASHIN: Mr. Chairman, with your permission I will introduce my associates. Mr. McFarlane of the McGregor Clinic in Hamilton; Dr. Patterson of the Oshawa Clinic in Oshawa; Mr. Wildblood of the Oshawa Clinic in Oshawa.

THE CHAIRMAN: Proceed please Dr. Strashin.

DR. STRASHIN: Mr. Chairman, to meet the problems posed by the ever increasing complexity of medical science and the ever increasing utilization of medical services and aware of the limits of one man's capabilities there has evolved in the practice of medicine,

---On resuming at 2:45 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning will be from the Ontario Association of Medical Clinics and it will be Exhibit 265, and Dr. Strachin will introduce his group and speak to the brief.

Submission of the Ontario Association of Medical Clinics

---EXHIBIT No. 265:

PRESENTATION OF

THE ONTARIO ASSOCIATION OF MEDICAL CLINICS

Dr. J. Patterson

Dr. STRACHIN: Mr. Chairman, with your permission I will introduce my associates, Mr. McFarlane of the McFarlane Clinic in Hamilton; Dr. Patterson of the Oshtemo Clinic in Oshtemo; Mr. Wildblood of the Oshtemo Clinic in Oshtemo.

Strachin.

Dr. STRACHIN: Mr. Chairman, to meet

the problems posed by the ever increasing complexity of medical science and the ever increasing utilization of medical services and aware of the limits of one man's capabilities there has evolved in the practice of medicine



1
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3 a greater inter-dependance of various practitioners,
4 specialties and diagnostic services. Clinic practice
5 is a product of this evolution and has had ever increasing
6 patient acceptance. Clinic practice provides a climate
7 where a number of physicians - both generalists and
8 specialists, can devote their skills and pool their
9 wisdom to the patient free from economic competition
10 between themselves, in an atmosphere of mutual helpfulness
11 and security. Clinic practice provides diagnostic and
12 therapeutic facilities which are immediately available
13 to the patient. Clinic practice attempts to achieve

- 14 a) comprehensive medical and diagnostic
15 care,
- 16 b) economic medical care,
- 17 c) conservation of the doctor's energy,
18 time and patience,
- 19 d) conservation of man-power hours
20 for the patient,
- 21 e) physicians abreast of medical
22 advances and not over-worked.

23 All this has involved most clinics in
24 heavy investments of money to provide the necessary
25 plants, administrations, diagnostic and therapeutic
26 equipment and facilities essential to such a programme.

27 RECOMMENDATIONS

- 28 1. The evolution of medical practice
29 should not be stunted.
- 30 2. The growth, spread and use of clinic
groups should not be compromised.



a greater inter-dependence of various practitioners, specialists and diagnostic services. Clinic practice is a product of this evolution and has had ever increasing patient acceptance. Clinic practice provides a climate where a number of physicians - both generalists and specialists, can devote their skills and pool their wisdom to the patient free from economic competition between themselves, in an atmosphere of mutual helpfulness and security. Clinic practice provides diagnostic and therapeutic facilities which are immediately available to the patient. Clinic practice attempts to achieve

(a) comprehensive medical and diagnostic

care,

(c) conservation of the doctor's energy

time and patience,

(b) conservation of manpower hours

for the patient,

(c) physicians' interest in medical

advances and not over-worked.

All this has involved most clinics in

heavy investments of money to provide the necessary plants, administration, diagnostic and therapeutic equipment and facilities essential to such a programme.

1. The evolution of medical practice

should not be stunted.

2. The growth, spread and use of clinic

forms should not be compromised.



Strashin

12289

3. No legislation should dissipate the time, effort and money which clinics have expended in developing diagnostic and therapeutic facilities.

4. The Ontario Association of Medical Clinics offers its offices in compiling relevant facts, statistics and information relating to clinic practice.

THE CHAIRMAN: Thank you Doctor. Would it be correct to accept the definition of clinic practice as synonymous with what is called in other places group practice?

DR. STRASHIN: Yes, I would think so Mr. Chairman.

THE CHAIRMAN: You gentlemen who are here, you represent clinics in cities and fairly large centres, Hamilton and Oshawa, and we can see how that development goes well in an urban community. We have had a great deal of discussion, not so much here in Toronto or in Montreal, but in the Prairie Provinces and in the Atlantic Provinces, and particularly say in a place like Newfoundland, about the development of clinics, or group practice, as an answer to the providing of services in the rural areas, and perhaps in the more remote areas.

Do you gentlemen have any views to express on that phase of it particularly, and whether you are able to see some kind of an arrangement that might be worked out, whereby groups might be the solution to the isolated area and to the isolated practice?

DR. STRASHIN: Mr. Chairman, first of all in the provision of medical services to any community, these medical services must be economic. By that I mean

3. No legislation should disallow the
time, effort and money which might have been expended in
developing diagnostic and therapeutic facilities.

4. The

Clinic offers its offices in convenient parts of the
statutes and information relating to clinical practice.
THE CHAIRMAN: Thank you, Doctor. Would
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development goes well in an urban community. We have
had a great deal of discussion, not so much here in
Toronto or in Montreal, but in the Pacific Provinces and
in the Atlantic Provinces, and particularly in a
place like Newfoundland, about the development of clinics
or group practice, as an answer to the provision of
services in the rural areas, and perhaps in the more
remote areas.

Do you gentlemen have any views to

express on that phase of it particularly, and whether
you are able to see some kind of an arrangement that
might be worked out, whereby groups might be the

solution to the isolated areas and to the isolated practices?
all in the provision of medical services to the community.
These medical services must be provided, by that I mean



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3 it is uneconomic to set up a group of even two or three
4 practitioners with diagnostic facilities to serve a
5 small area of a community of two or three hundred people,
6 so therefore in thinking about groups, one of the first
7 things I think we have to consider is that the areas or
8 in which they are set up have enough population to --
9 economically make the best use of a group, whether it
10 be a group of two or three men.

11 Now, it is our feeling that in smaller
12 areas groups of two or three men could very well be
13 established if they were given the necessary moneys
14 which are required to set up a ---

15 THE CHAIRMAN: Do you mean subsidies?
16 DR. STRASHIN: No Mr. Chairman, I
17 don't mean subsidies.

18 THE CHAIRMAN: Money loaned?

19 DR. STRASHIN: Money loaned to them
20 so that they could set up their necessary offices and
21 the equipment that is necessary for that area.

22 THE CHAIRMAN: (You see, we can accept
23 very readily, anyone will accept very readily that you
24 cannot have a group for two or three hundred people,
25 but the question isn't quite that. It is a question of
26 organizing ten or twelve or fifteen communities of two
27 or three hundred to be served by a group, into a sort
28 of a zone, something of this kind, which would serve --
29 and what we are thinking of is something not necessarily
30 the same, but along the lines of the group practice
in upstate New York at Albany, in the rural area there.
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Strashin

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3 Hamiota, Manitoba.

4 DR. STRASHIN: Mr. Chairman, Mr.
5 McFarlane will speak to that.

6 MR. McFARLANE: Mr. Chairman, with
7 apologies to the doctors present for me a layman attempting
8 to answer the question which you have just raised ---

9 THE CHAIRMAN: No, I quite understand.
10 I think it is quite a logical thing, because the business
11 arrangement is also essential in the thing I am talking
12 about.

13 MR. McFARLANE: That sir is quite true.
14 The business arrangement, however, must be secondary in
15 all cases. The basic requirement is, as Dr. Strashin
16 has said, that the community, or communities to be
17 served be adequate to justify the presence of physicians
18 in whatever specialties they may represent. I think that
19 a short look at the history of development of group
20 practice, and this will be very short I can assure you
21 sir, may be of some value in this respect, because
22 after all the natural evolution of group practice, or
23 any other enterprise, bears some relationship to the
24 need as well as the opportunity, because the need must
25 be there before there is an opportunity.

26 We could look at the classic example
27 of group practice, which of course is Mayo's in Rochester,
28 Minnesota, where they started in a small town, serving
29 a wide community of other towns within a radius of I
30 don't know how many miles. The present clinic is not
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other places. When I say look at the evolution a bit, I mean by that that in the west, the mid-west states, particularly, there has been a great development of group practice, where the urban communities for the most part are small. There are not large cities. There have been some clinics in large cities, yes, throughout the United States and Canada as well.

The development of the groups which has continued here, have for some reason or other been primarily in the larger cities. In eastern Canada there has not been nearly so much growth of group practice as in the west. I don't know why, but to try to answer your question, and I am afraid it may not be a satisfactory answer, I feel that in a small community, on a group of communities, a group will probably function better than it will in say the City of Toronto, because in the small community there is a limitation on the quality and quantity of facilities, the expensive equipment, the hospital beds, and so on, that are available. If it can be combined and co-ordinated, so that between the group and whatever hospital facilities, which may be quite small, the necessary x-ray, the necessary pathological labs, and so on, are provided, under whose aegis, or whose finances it is not the problem at the moment.

You are asking if you think it will work.

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STONEMAN

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I think it will work better. I has worked better in the past in the small communities than in the large cities, principally because in the large cities there are adequate facilities for the practice of real good medicine; there are not in the small communities. There is no reason why groups couldn't function effectively there.

THE CHAIRMAN: We are trying to see what may emerge as a pattern. We have had impressed upon us that there must be equal opportunity, equal access to good quality medicine, wherever you may live in Canada. Now, that is an ideal statement; it is impossible of realization. You cannot give some man on the shore of Labrador equal services as someone in Montreal or Toronto, but there are other areas where it may be as thinly-populated area, but still with a reasonable number of people who are not being served or may be inadequately served by one physician who simply cannot work 24 hours a day and seven days a week. What we are trying to see is if there is a way -- we don't back away from the expression "subsidization" --- that would provide a clinic with diagnostic services and which from its very nature would save a great deal in patient admission to hospital.

DR. STRASHIN: Well, Mr. Chairman, Dr. Thorlakson in the brief to the Commission suggested a national advisory board on group practice. The only direction in which we would differ from Dr. Thorlakson in a national advisory board is that our feeling is that it should be under the aegis of the Canadian Medical

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Association and perhaps a national board, but group practice might be set up under their direction and their sponsorship, whose job it would be, as Dr. Thorlakson pointed out, to advise and promote group practices across Canada.

THE CHAIRMAN: I think we might say that we haven't a very pronounced interest in group practice in the large urban communities; that is just a natural development, more a matter of convenience as much as anything else. Group practice in the rural areas may be necessary to provide the service.

DR. PATTERSON: Mr. Chairman, I believe your assessment of the situation is quite correct. We doctors who are in group practice feel we do better work because we are in group practice; we work with our associates, we discuss questions we have amongst ourselves, there is no time lost, there are all types of inter-office assistance, and so on. If you are going to give assistance to the country as a whole, properly set up and equipped groups are necessary.

MR. McFARLANE: Mr. Chairman, may I interpolate one comment here, and I will be quiet.

THE CHAIRMAN: We are here to talk.

MR. McFARLANE: What Dr. Patterson said I think is absolutely correct, and it points up one point, and that is I am thoroughly convinced that the prime requisite for a successful group -- and I not referring to the financial success; that is secondary and it will come if the rest is all right --- but one of the prime requisites is that the individuals who are part of



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the group, the professional man, they think they can practise better medicine in a group. My point is you cannot draft people and say you are in the army, boys, practise your profession.

THE CHAIRMAN: They don't draft the lawyers; they had sense enough to do that years ago.

MR. McFARLANE: They are constitutionally unsuited to have someone working with them all the time.

COMMISSIONER McCUTCHEON: Mr. McFarlane, you said, as I recall it, that you thought that group practice should develop more readily, shall we say, in the rural areas than in the large cities, and I gather you feel it is more important that it should develop in these areas, or at least as important. Now, is there any explanation as to why it hasn't developed in the rural areas in Ontario?

MR. McFARLANE: Frankly, I am at a loss to understand it, sir.

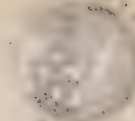
COMMISSIONER VAN WART: Looking at your Page number 2, I notice you say that there are 100 medical groups in Ontario with 550 physicians. That averages out between 5 and 6 per clinic. Those are very small groups, are they not?

DR. STRASHIN: Most of them are, sir.

THE CHAIRMAN: You haven't anything that compares with the Regina Clinic which has 55 or 70?

MR. McFARLANE: That is the largest clinic in Canada, sir.

COMMISSIONER VAN WART: You go on to speak of economy in setting up a clinic, but with a very



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MR. McFARLANE: That is the largest

clinic in Canada, sir.

COMMISSIONER VAN WART: Can you go on to

aspect of economy in setting up a clinic, but with a very



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small group like that, I can't see how it can be efficient and accomplish what you are saying it is going to accomplish. You must have some groups of three.

DR. STRASHIN: Even a group of three practises better medicine than a ---

COMMISSIONER McCUTCHEON: A group of one.

DR. STRASHIN: Than a group of one. I don't mean to imply that a group of one cannot practise very good medicine. I think that a group of one can call in specialists, can get information, can pool the wisdom of its confreres.

THE CHAIRMAN: I don't think you have to defend that position at all.

Of the 550, when you are speaking of groups, are these groups of diverse specialties or callings and not just four or five orthopaedic surgeons sharing one office?

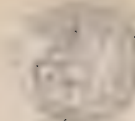
DR. PATTERSON: I think they don't qualify.

MR. McFARLANE: It is a real mixed bag.

COMMISSIONER VAN WART: I haven't the figures offhand. How many doctors in Ontario are there?

MR. McFARLANE: 8,140.

COMMISSIONER VAN WART: It would seem to me that a group of 550 in 8,000 doctors is a very small proportion, and to say the solo man doesn't do as good work as a group man, the inference is that you are not



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COMMISSIONER VAN WART: I haven't

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there?

MR. ROBERTSON: 5,100.

COMMISSIONER VAN WART: It would seem

to me that a group of 550 in 3,000 doctors is a very small
proportion, and to get the solo man doesn't do as good
work as a group man, the reference is that you are not



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getting the best medicine in Ontario.

One thing I want to bring out here is that in your hospitals you have solo practitioners, but as far as the practice of medicine is concerned they are really active, they accomplish everything that you set out, that you are trying to accomplish. Have you any argument about that?

DR. STRASHIN: Yes. In hospitals group practice is practised, but it is not practised as economically as it could be in groups practising outside, because their practice is with patients who are occupying hospital beds, which is an expensive and uneconomic way of doing things. We submit that a great many of these situations could be handled on the outside in groups, especially diagnosis, much more economically.

COMMISSIONER VAN WART: You would feel or not feel that if you had in the rural districts a small hospital supplying several communities with service and the doctors are there as solo doctors around that hospital, they wouldn't give as good service as if they were in a group practising in that area?

DR. STRASHIN: They might give as good service, but it would be a greater cost if these people were admitted to the hospital and occupy the hospital bed strictly for diagnostic purposes.

MR. McFARLANE: Mr. Chairman, I think I see Mr. Van Wart's point, and I would like as a layman to answer his argument here, because obviously the two doctors who are present are convinced that group practice is considerably more efficient than solo practice or they



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I see Mr. Van Wart's point, and I would like as a lawyer

to answer his argument here, because obviously the two

doctors who are present are convinced that group practice

is considerably more efficient than solo practice or that



12298 McFarlane

would not be in group practice. I am also convinced from 17 years exposure to it.

However, it would be utterly foolish for us to say that no good medicine can be practised outside a group, because that is completely wrong, and as I said already, there are doctors who are constitutionally unsuited to practise in a team.

Your question about two or three doctor groups, the only answer to that, I think, is the obvious one, that everything must start somewhere. Out of 1,154 groups with 10,000 physicians surveyed by the Americans, United States Public Health Service, 660 had three to five full-time physicians, 279 had six to ten, 87 had eleven to fifteen and 128 had sixteen or over. Only 11% were over fifteen doctors.

You cannot have a completely comprehensive medical coverage within a group of, say, ten men; the activities are too diverse. On the other hand, you can with the sort of organization that exists at the present time in the Province of Ontario, in fact, I suspect throughout the Dominion, of your area and regional and what-not hospitals where there are most adequate facilities for carrying everything than your less complete institutions on the perimeter, and you can certainly provide adequate care with less than these facilities in that area, and if that coverage is performed by that group, it is going to be a little more efficient, a little better coordinated, but not necessarily to me, the patient, any better medicine in any one case, but it should be in the picture.



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COMMISSIONER BALTZAN: Gentlemen, who are eligible in the Ontario Association of Medical Clinics? I mean, two or three physicians, fifteen physicians. Who are?

DR. STRASHIN: Our Association requires a group of at least three.

COMMISSIONER BALTZAN: At least three?

DR. STRASHIN: Yes.

COMMISSIONER BALTZAN: You were speaking about doctors, and my friend Dr. Van Wart mentioned about doctors who were doctors working in a hospital or out of a hospital in a small area, and you said that they do not work as economically as when they are organized themselves, whether it is in the hospital or outside the hospital. That is what you said?

DR. STRASHIN: Yes.

COMMISSIONER BALTZAN: And would you also say that working independently, say, within the hospital or together their work isn't as well coordinated perhaps, as if they were organized?

DR. STRASHIN: Yes.

COMMISSIONER BALTZAN: The growth and spread and use of clinical groups should not be compromised, you say?

My question is, what are the threats, what have you in mind that this is not continuing to spread or perhaps even be inhibited?

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4 ipw DR. STRASHIN: Well, sir, in the brief
5 we point out one example of interference which we feel
6 is compromising our situation. It is that sort of
7 thing that would threaten the growth and expansion and
8 spreading of clinical groups.

9 COMMISSIONER BALTZAN: It is that sort
10 of thing I would like to know about.

11 DR. PATTERSON: Sir, I have been with
12 a group that may be of interest to you, gentlemen.
13 When I joined there were five in the group. There are
14 20 full-time members and several part-time specialists.
15 During that time I have seen a laboratory develop from
16 a minor one-girl operation to a four-girl operation;
17 our x-ray from a single technician to three and various
18 developments such as that.

19 If the Ontario Hospital Services
20 Commission is going to take over all diagnostic work
21 we are going to be compelled to send that phase of our
22 practice that is now done in our four walls where we
23 can get immediate results, do the x-rays the same day
24 and at the same visit and expeditiously deal with the
25 situation - we will have to send that outside, the
26 people to the hospital for that work to be done, wait
27 for the report to come back, bring our patient back.
28 It just adds to confusion.

29 THE CHAIRMAN: The answer to it would
30 be out-patient responsibility should be included in
the clinic walls in this country.

DR. PATTERSON: That is right. It is
only one of the very strong points that makes group



Patterson 12301

practice so satisfactory to some of us. I have been in it for 15 years now. I certainly wouldn't want to practise on my own.

COMMISSIONER McCUTCHEON: Are you suggesting that the Hospital Services Commission take over payment for diagnostic facilities and lab facilities in your group?

DR. PATTERSON: No.

THE CHAIRMAN: He says if they do it in the hospital they should go all the way.

COMMISSIONER McCUTCHEON: I think there would be trouble going that far, but it is up to him.

THE CHAIRMAN: Isn't that what you said, "if"?

DR. PATTERSON: If you are going to take it over, but we would like - like most of your gentlemen like to be masters of your own ship.

MR. McFARLANE: I think, Mr. Chairman, Dr. Patterson did, in his comments, express the key to this. It is not an economic key.

THE CHAIRMAN: We understand.

MR. McFARLANE: That is not the point. The key is simply that the physician or surgeon dealing with the patient can get his reports.

THE CHAIRMAN: But the basis is economic, if you are going to get paid x-rays at the hospital, that is the thing that is going to pose the problem? Getting it free at the hospital and not at the doctor's, they are going to have to go to it and that is basically

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DR. PATTERSON said, in his comments, express the key to
this. It is not an economic key.

THE CHAIRMAN: We understand.

MR. TATARIAN: That is not the point.

The key is simply that the physician or surgeon dealing
with the patient can get his reports.

THE CHAIRMAN: But the point is economic,
if you are going to get paid x-rays at the hospital,
that is the thing that is going to cause the problem?
Getting it free at the hospital and not at the doctor's,
they are going to have to go to it and that is basically



McFarlane 12302

economic. The results may be a slowing down in the process and be more unsatisfactory to the doctor and less satisfactory to the patient, but for the moment that is the problem?

MR. MCFARLANE: Mr. Chairman, I cannot help but protest at the use of the word "free".

THE CHAIRMAN: The use is here and there.

COMMISSIONER BALTZAN: Then, according to your view, this is one threat. If that happens to be the case, that all these necessary diagnostic services are delivered on an out-patient basis only in the hospital it is a threat to your own set-up as clinic groups?

DR. STRASHIN: There is one other thing, of course, and that is the clinic groups require a great deal of money and enterprise to be borne and to expand. This requires an atmosphere of confidence.

COMMISSIONER BALTZAN: Is there any threat to the service of patients in that there may be suddenly a considerable overlap of hospitals in Ontario?

DR. PATTERSON: I don't believe they could cope with it with their existing facilities.

COMMISSIONER BALTZAN: Lastly, gentlemen, and thank you for answering the other questions, clinic practice attempts to achieve, you say here, economic medical care. By that I take it, and correct me, does it reduce the cost to the patient?

DR. STRASHIN: Yes.

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Patterson 12303

that one of the reasons which helps to reduce the cost is within the group consultations are not pyramided?

DR. PATTERSON: That is right.

COMMISSIONER BALTZAN: The group works as a unit and the patient is charged sort of a composite rather than an individual fee?

DR. PATTERSON: There is no question but what the fee would be considerably greater if the patient had to go to another place, see another man with a separate appointment and require a full period of his time. When you bring him into your office and say what do we do with this and deal with it on the spot - it is usually just forgotten.

COMMISSIONER VAN WART: Do some members of your clinic practice, as individuals, under a common roof, and with a common lab and collect fees, etc.?

DR. STRASHIN: Not in our Association.

COMMISSIONER VAN WART: None of them?

DR. PATTERSON: They are not admitted to the Ontario Association of Medical Clinics if they practise as individuals.

DR. STRASHIN: May I say one other thing as far as your question is concerned? It is more economic in that the patient's time is conserved. In one visit a good deal can be accomplished in a group whereas, if he were being referred to different people outside the group this would require more time off for him, more appointments, more loss of time from work which is uneconomic.



Patterson 15303

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Patterson

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COMMISSIONER VAN WART: Your clinic does not practise as a corporation?

DR. PATTERSON: No.

DR. STRASHIN: No.

COMMISSIONER VAN WART: You practise as individuals?

DR. PATTERSON: Partnership.

DR. STRASHIN: As a partnership.

COMMISSIONER VAN WART: And you derive your remuneration from a common pool?

DR. PATTERSON: That is right. That is one of the requisites for entry into the Ontario Association of Medical Clinics, so there is some control over the members of each group.

MR. McFARLANE: In actual fact, no clinic practises as a clinic. The individuals within it practise as individuals. The pooling is strictly for administration, records and operating costs. Responsibility for the care of a patient is a personal responsibility, not an institution. The institution would have secondary liability, of course, but there is no such thing as a corporation or any clinic, regardless of its corporate structure practising medicine. It doesn't. It cannot.

THE CHAIRMAN: Thank you very much, gentlemen. We might mention this question of clinic practice or group practice is much more significant in terms of trying to find an acceptable way of getting better service and more accessible service to the more remote areas in the country than in the cities.



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TORONTO, ONTARIO

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DR. STRASHIN: Mr. Chairman, may I
thank you and the rest of the Commissioners for listening
so kindly to our presentation?

THE CHAIRMAN: Thank you. We are very
grateful to you for having come.

DR. PATTERSON: Thank you very much.



OFFICE OF THE SECRETARY OF THE INTERIOR
WASHINGTON, D. C.

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Strasburg

WASHINGTON, D. C., MAY 1, 1905

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THE SECRETARY: The next submission will be that of the Ontario Osteopathic Association which will be known as Exhibit 366. Dr. Jaquith will introduce his group and speak to the brief.

--- EXHIBIT NO. 366: Submission of the Ontario Osteopathic Association.

SUBMISSION OF THE ONTARIO OSTEOPATHIC
ASSOCIATION

Appearances: Dr. R. Pocock
Dr. D.A. Jaquith
Dr. D. Firth
Dr. L.E. Jaquith

THE CHAIRMAN: Dr. Jaquith?

DR. D.A. JAQUITH: Mr. Chairman and members of the Commission, ladies and gentlemen, may I first introduce the members of my Committee. Dr. Roslyn Pocock on my right; Dr. Douglas Firth on my left and my brother, Dr. L.E. Jaquith, M.D., on my extreme left. We are all osteopathic physicians. Some of us have other degrees in addition.

THE CHAIRMAN: May I invite you to take a chair?

DR. D.A. JAQUITH: Thank you. Our brief is prefaced with a summary of recommendations, as you see. I will read right through from the beginning.

PREFACE

1. The Ontario Osteopathic Association wish to express their appreciation for this opportunity of contributing to the formulation of the principles of a comprehensive health service for the improvement of

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BRIEF

I. The Ontario Osteopathic Association

wish to express their appreciation for this opportunity

of contributing to the formulation of the principles of

a comprehensive health service for the improvement of



D.A.Jaquith 12307

the health standards of the citizens of Ontario.

2. OBJECTIVES OF THIS BRIEF are to bring to the attention of the Honourable Members of the Royal Commission the importance and benefits to the people of Ontario of inclusion of the osteopathic profession in any plan of Health Services or Health Insurance.

3. THE SUMMARY OF RECOMMENDATIONS:-

1. That co-operation and active consultation of all groups involved in health care be encouraged.
2. That regulation and control be on a provincial and/or national basis.
3. That the establishment of large jurisdictional areas be favoured.
4. That freedom of mutual selection by both patient and doctor be maintained.
5. That osteopathic physicians be integrated into the health services of Ontario on the same basis as medical physicians, and dentists.
6. That there be representation of all professions on the administrative board.

4. THE OBJECTIVES of the Ontario Osteopathic Association are to promote the public health, to encourage scientific research, and to maintain and improve high standards of medical education in osteopathic colleges; and further to promote the welfare of osteopathic medicine and of its practitioners in Ontario.



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5. The Ontario Osteopathic Association represents a total of seventy-nine osteopathic physicians registered in Ontario.

6. For the information of the Commission the following motion was passed by the Ontario Osteopathic Association, in formal business session, on May 2nd, 1961 - -

"The Ontario Osteopathic Association is in favour of total health insurance in principle."



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D.A. Jaquith

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7. The members of the Ontario Osteopathic Association believe in the principle of health insurance for the people of Ontario and are willing to co-operate in any scheme that is fair to both the patient and the physician.

- B R I E F -

8. For more than sixty years many thousands of the people of Ontario have depended on osteopathic care. Osteopathic physicians are fully qualified by education and training to render a complete service in improving public health. In addition to general medical therapeutics they are also trained in physical medicine and manipulative procedures. Prevention of ill health is a cardinal aspect of osteopathic medicine, and is accomplished by normalization of the musculo-skeletal system and other systems of the body.

9. Manipulative procedures by which this normalization is accomplished are responsible in a great many cases for preventing the encroachment of disease, and are most efficient and appropriate in the treatment of both acute and chronic illness.

10. While osteopathic physicians stress the value of manipulative procedures in the care of the patients, they also use all approved medical methods.

11. An accurate evaluation of osteopathic medicine can only be determined by reference to the courses and principles taught in the established educational institutions. This is given in detail in the submission of the Canadian Osteopathic Association.

12. Osteopathic medicine has wide recognition



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5 physicians the right to practice medicine in all its
6 phases. Ninety-seven percent of Osteopathic Physicians
7 in the United States now practice under such laws. Some
8 States have had these laws for as long as sixty years.
9 In no instance has a legislative body ever revoked the
10 privileges so granted. It must follow that these doctors
11 are discharging their duties skillfully and faithfully
12 in their care of the sick and injured.

13. In Ontario we co-operate with and
14 receive compensation from Workmen's Compensation Board
15 and most insurance companies.

14. There are many hospitals serving the
15 American public in such border cities as Detroit,
16 Cleveland, Toledo, Columbus and others - which are
17 staffed by osteopathic physicians who care for all types
18 of injury and disease, using all modern methods of
19 treatment.

20 CONCLUSION

21 15. It is our conviction that we have a
22 considerable contribution to make in the field of
23 medicine and that we are already doing so in a specialized
24 way. Therefore we have much to add to a program of
25 health services for the people of Ontario. We are
26 concerned about the man-hours of work lost through
27 illness that could be prevented, which increases the
28 cost of living and lowers our national productivity.

29 RECOMMENDATIONS

30 1. In the promotion of the highest
possible level of physical, mental, and social health,
it is in the interests of any health plan to have



expanding on that. What do you mean by that very general

statement?

generally we feel that some overall plan of health insurance or insured health so that all people, all levels of the population would receive adequate health care is perhaps eventually desirable.

We hope that this will be brought about in such a way so that it will not become just a Government expense but, as I expanded in a later part of the brief, it would be fair to both the patient and the physician.

I think in principle we feel that we are agreeable to such a plan.

THE CHAIRMAN: When you use the words "insurance in principle," do you mean premium based?

premium may be paid in various ways.

THE CHAIRMAN: Premium based as distinct from paid from taxation? Premium from the individual beneficiary?

DR. D.A. JACKSON: I think we feel that this is something that has to be worked out. Whether it is tax supported or otherwise, it would be decided by people who are much more competent than we are.

THE CHAIRMAN: Other people have seen fit to give us their views on this important principle. If you have any to offer, we would be pleased to hear them. If you haven't all right.

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co-operation and active consultation among all groups involved in health care, including the osteopathic profession.

2. That while provincial autonomy in health matters should be maintained, there should be a measure of federal supervision to ensure uniform standards of service and to co-ordinate appropriate action in emergencies such as catastrophe or epidemic.

3. That large jurisdictional areas of administration be established ensuring greater uniformity and fairness in both urban and rural communities.

4. That freedom of mutual selection by both patient and physician be maintained.

5. That osteopathic physicians be integrated into the Health Services of Ontario on the same basis as medical physicians and dentists.

6. That each participating profession should be adequately represented on the advisory or administrative board governing the operation of any plan instituted.

Respectfully submitted.

That is our brief.

THE CHAIRMAN: Thank you Dr. Jaquith.

DR. D. A. JAQUITH: I don't think I have any significant additions to make, but questions may bring out some factors that would be pertinent.

THE CHAIRMAN: You say at the foot of page one "The Ontario Osteopathic Association is in favour of total health insurance in principle." Would you mind

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7 DR. FIRTH: I think actually it leaves
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9 straight contributory basis. I think that is the basis
10 of the background for health insurance that so many
11 people do not have adequate medical care. In spite of
12 the way we talk about it, they do not get it. It is
13 not available. I think it should come from taxation
14 for a certain portion of the population.

14 THE CHAIRMAN: For what portion?

15 DR. FIRTH: For those who are unable
16 to pay. There is going to have to be some level of
17 income, probably. I think you had a group appear
18 yesterday who was a very good example in that the care
19 she was getting, she didn't feel it was adequate. She
20 was getting quite a run-around. I think a proper health
21 scheme of some sort would remove that inequity.

21 DR. D. A. JAQUITH: I agree with Dr.
22 Firth in this. There are certainly people who could not
23 make any contribution towards their health care.

24 THE CHAIRMAN: For those you would
25 have the premiums paid from taxation?

26 DR. D. A. JAQUITH: That is right.

27 THE CHAIRMAN: Now what do you see,
28 what is in your mind in the recommendation number 3,
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DR. D.A. JAQUITH: I think in the back of our mind was the fact that sometimes one City may vary in its interpretation of regulations from another City, or one county from another county. Whereas, if jurisdictions were large enough that would be eliminated.

THE CHAIRMAN: What do you mean by "large"? Are you talking on a provincial basis?

DR. D.A. JAQUITH: I think so. Yes. I think so.

THE CHAIRMAN: Recommendation number one "That co-operation and active consultation of all groups involved in health care be encouraged."

DR. D.A. JAQUITH: On page 3 I have enlarged on that. The first listing of the recommendations was just a brief outline. In the promotion of the highest possible level of physical, mental, and social health, it is in the interests of any health plan to have co-operation and active consultation among all groups involved in health care, including the osteopathic profession.

At the present time, we are inclined to be left out. I mean not of our own inclination, but we are sort of passed over.

THE CHAIRMAN: What do you mean by that?

DR. D.A. JAQUITH: Our services are not generally included.

THE CHAIRMAN: Just take that a little further. What do you mean by that? Let me put it this

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D.A. Jaquith

12315

way: You stand very firmly here for the right of the patient to choose.

DR. D. A. JAQUITH: Correct.

THE CHAIRMAN: So what is the complaint you have of your being left out? That there are not enough patients choosing you?

DR. D. A. JAQUITH: No, I wouldn't agree to that at the moment.

THE CHAIRMAN: I was just wondering, if that is the basis of the demand or need for the services.

DR. D. A. JAQUITH: This brings us into a discussion of relationship with other branches of the medical profession in which we are not fully recognized in spite of our qualifications, either by law or ---

THE CHAIRMAN: When you say "not fully recognized" ---?

DR. D. A. JAQUITH: We are licensed under the Drugless Practitioners Act and therefore we are considered different from medical physicians, for instance, or dentists or other qualified people.

THE CHAIRMAN: How does that manifest itself in your practice?

DR. D. A. JAQUITH: In its limitations. In the limitations imposed on us.

THE CHAIRMAN: In what limitations? I will start you off here. You have not the right to admit somebody to a hospital?

DR. D. A. JAQUITH: That is correct.



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In the limitations imposed on us.

THE CHAIRMAN: In what limitations?

I will start you off here. You have not the right to admit somebody to a hospital?



D.A. Jaquith

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THE CHAIRMAN: That is one thing you are complaining of.

DR. D. A. JAQUITH: We have not the right to prescribe what few drugs we might wish to use, although we may be qualified to use them.

THE CHAIRMAN: You have no right to prescribe drugs at all?

DR. D. A. JAQUITH: That is right.

THE CHAIRMAN: At all?

DR. D. A. JAQUITH: That is right.

COMMISSIONER STRACHAN: Do they cross the line?

DR. D. A. JAQUITH: Yes. As my statement said, about 98% of osteopathic physicians in the United States practise under a full licence. Their D.O. degree is on par with M.D.

COMMISSIONER STRACHAN: They carry on surgical procedures as well?

DR. D. A. JAQUITH: Yes, that is correct.

THE CHAIRMAN: We had a considerable discussion with your National Organization when they were here about three weeks ago and I think we were told of one osteopathic college in California, the degree from which was recognized by the American Medical Association and entitled the graduate of that school to membership in the American Medical Association, if the person desired it.

DR. FIRTH: The degree though is M.D., not D.O. That was a sudden change, very recently in



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3 which that college no longer gives the D.O. degree.
4 Gives the M.D. degree now.

5 COMMISSIONER STRACHAN: Based on the
6 D.O. curriculum?

7 DR. FIRTH: That is right, yes, they
8 take the D.O. curriculum. At the end they give them a
9 M.D. degree.

10 THE CHAIRMAN: Apart from pride of the
11 past is that the way for this co-operation?

12 DR. FIRTH: I think that group has
13 felt that, but they are in the minority in the profession.
14 The majority don't feel that.

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THE CHAIRMAN: Could the minority be right?

DR. FIRTH: Yes, it is always possible. I think a hundred years from now, fifty years from now, I don't think at the moment we can say that. It is not apropos.

THE CHAIRMAN: But you are talking here about cooperation, and bringing all the health services people together. If there is a possible solution which is working out in practice in a State like California ---

DR. D.A. JAQUITH: I don't think that is quite practical. As a matter of fact it is in a state of flux at the moment. There has still to be a referendum in the State.

THE CHAIRMAN: All right, you say that solution is out. What is your solution for this?

DR. D.A. JAQUITH: Our solution is that we be recognized on a par with the medical profession. We want to retain our D.O. Degree, and practise, not as distinct from the medical profession. We are a branch of medicine. There are many people in the medical profession who are different from their fellows, and that is about all the difference there is with us, but we are forced to practise under a restricted licence, which considerably curtails our benefits to the patient in a great many ways.

Mind you, we get by, and we do some remarkable things, I think, in our profession without these other advantages, but it would ease things for both the patient and the doctor many times if we were given the

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D.A. Jaquith 12319

status that we think we deserve.

COMMISSIONER McCUTCHEON: That is a matter, of course, for the Provincial Legislature?

DR. D.A. JAQUITH: That is true. That is why we didn't bring it in the discussion in our brief.

DR. FIRTH: I think that the knowledge we have, disregarding the number of patients, is not being adequately used, and we think that under a national health scheme that our brains ought to be picked a little more than they are being picked now for the benefit of the patient, and we see many cases in North America that have not received the proper care to restore them to health. Perhaps it goes the other way. On the other hand, we do see these cases, and we feel that if there was a national health scheme the facilities and knowledge we have should be incorporated. We would like to be called in as consultants, perhaps by physicians who meet cases where they feel that the knowledge we have can be of use. It is already being done, but on a private practice scale.

We have orthopaedic physicians and general practitioners calling us in consultation and referring patients. We would like to see that incorporated in the national health scheme, in which the osteopathic physicians are not set off in a little niche by themselves.

THE CHAIRMAN: This question of fragmentation of health services is a matter of some concern.

DR. FIRTH: You already have it in the practice of medicine in your specialty groups. The way the laws are set up in Canada, we are more or less

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Firth

12320

specialists, although we feel ourselves as general practitioners. We think that what we can do under the present legislation, and there is always possible ---- You had Dr. Hannah and Dr. Dawson speak to you on possible pending changes in the College of Physicians and Surgeons brief a while ago, and if that occurs we feel we would be even closer to being recognized on a par, and we feel that when legislation is written the public would be denied a type of therapy that is in addition to what we expect they will get already.

THE CHAIRMAN: You claim the right to practise general medicine?

DR. FIRTH: That is so.

THE CHAIRMAN: Now then, claiming that, can you ask exemption from the tests, or whatever form it may take, examination that the general practitioner of general medicine must take in order for him to qualify?

DR. D.A. JAQUITH: No, we don't ask that.

DR. FIRTH: We believe we can pass it, but the tests are set up in such a way now that it is impossible for us to take it. You must be a certain type of graduate, you must be anointed in such a way that you can take the tests. We are willing to take the tests, because our doctors are refusing equivalent training.

COMMISSIONER McCUTCHEON: This being a matter of Provincial jurisdiction, are you saying to us that if we were to recommend a health scheme that involved contribution of cash money from the Federal Government,



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Fifth

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COMMISSIONER ROBERTSON: This being

a matter of Provincial legislation, are you saying to us that if we were to recon and a health scheme that involved contribution of cash money from the Federal Government,



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that money should only be available to a province which changed its laws to recognize you as fully qualified medical practitioners?

DR. FIRTH: No, I wouldn't say that, because we cover most of the provinces. I don't think that the public there should be denied the services of those physicians if they wished to use them. That is the point I think you are trying to make, that where you have a physician in a province the public should not be denied his services.

COMMISSIONER McCUTCHEON: When you are putting it on a narrower basis, assuming that such a recommendation was made, we should recommend that one of the health services be included, being osteopathic services, the extent of those services would be determined by the various provincial jurisdictions. Is that it?

DR. FIRTH: I believe the wording you will use in there, since it is so frequently done, is that the care received by the person will be from a qualified medical practitioner, and in that case you are again using the provincial law to qualify that man.

COMMISSIONER McCUTCHEON: What is it that you want? Are you coming to say if such a recommendation were made, you would want us to include the services of osteopaths, even though those services may be confined to a narrow jurisdiction, to a narrow area, by reason of provincial laws, we should nevertheless recommend that those services, such as you can lawfully give, be included as eligible for payment under such a scheme?

DR. FIRTH: I would say so.



D.A.Jaquith 12322

DR. D.A. JAQUITH: Yes, I agree to
that.

COMMISSIONER McCUTCHEON: Then you
would fight out your own battle with the Province?

DR. FIRTH: Yes, that is not your
battle.

DR. D.A. JAQUITH: I would like to
express our appreciation for the courtesy of the
Commission in bearing with us in our problems.

THE CHAIRMAN: No, no, you have a
right to be here.

THE SECRETARY: Mr. Chairman, the
next submission will be that of the Canadian Podiatry
Association and the Ontario Podiatry Association. They
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---EXHIBIT NO. 367: Submission of the Canadian Podiatry Association.

---EXHIBIT NO. 367A: Submission of the Ontario Podiatry Association.

S U B M I S S I O N S . O F
THE CANADIAN PODIATRY ASSOCIATION AND THE ONTARIO PODIATRY ASSOCIATION

APPEARANCES:

DR. R. SMITH
DR. NORMAN GUNN
DR. WILFRED LANE
MR. DAVID ONGLEY

DR. SMITH: Mr. Chairman, first I would like to introduce to the Members of the Commission, my colleagues. On my right is Dr. Norman Gunn, President of the Ontario Podiatry Association and Director of the hospital clinics of that Association. On my left is Dr. Wilfred Lane, President of the Canadian Podiatry Association. We may have another member, a member of the learned law profession, who has been tied up, Mr. David Ongley, but we will proceed.

THE CHAIRMAN: We would not ask you to proceed if you were not quite ready.

DR. SMITH: We are ready, sir. Mr. Ongley is more or less an ornament.

THE CHAIRMAN: Is he a solicitor?

DR. SMITH: Oh, yes, I was being facetious.

Submission of the Canadian
Podiatry Association.

---EXHIBIT NO. 387:

Submission of the Ontario

---EXHIBIT NO. 387A:

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Smith 12324

(A) The Ontario Podiatry Association respectfully recommends to the Commission the establishment of a National Canadian Podiatry College to increase the number of practitioners to meet the existing and growing need for the treatment of foot problems.

(B) This Association also recommends to the Commission the formation of a National Podiatry Council for the uniform provision of a high standard of podiatry practice to the Canadian public.

(C) This Association further recommends to the Commission that they encourage Underwriters, such as Insurance Companies, Credit Unions etc., to pay claims to the Canadian public for foot problems treated by anyone licensed to do so in that particular locality.

These are the recommendations, sir.

THE CHAIRMAN: In your recommendation number (B), just what do you suggest could be done toward the formation of a national podiatry council that cannot, or should not be done by the profession itself?

DR. SMITH: Well, we feel, sir, that the national council would standardize qualifications more uniform ----

THE CHAIRMAN: No, that is the council, but I mean the organization of it, bringing it into being. I mean, isn't this something wholly within your own hands now?

DR. SMITH: We feel, sir, that this would govern somewhat like the Canadian Medical Council.

THE CHAIRMAN: But the Canadian Medical Council came into being because of the initiative of the

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Smith 12325

Canadian medical profession. I mean, it was not imposed from on top, as I understand.

DR. SMITH: That we agree with, sir, but as the number of podiatrists in Canada is much smaller than the number of physicians, surgeons, etcetera in Canada, when the Canadian Medical Council was formed, some national recognition from the authorities might be, in fact would be essential. As we recommend here, a college.

THE CHAIRMAN: Do you mean you want Government to call a group together to form a council?

DR. SMITH: That would help.

THE CHAIRMAN: My question to you is, why don't you do it yourself?

DR. LANE: We have attempted to do this. We have drawn up an Act, and have presented it to the various Departments of Health of the various Provinces. It was rejected by some and it was accepted by others, and this is where it stands. True, it is a Provincial matter. We have gone as far as we think we can go, and it has ended there.

COMMISSIONER McCUTCHEON: Do you practise now under The Drugless Practitioners' Act?

DR. LANE: No, sir, we have our own Act.

DR. SMITH: In Ontario, and the Provincial Acts throughout Canada.

THE CHAIRMAN: Are there any Provinces in which you haven't an Act?

DR. SMITH: Yes.



Smith 12325

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Lane 12326

THE CHAIRMAN: Which?

DR. LANE: Quebec and the Maritimes.

THE CHAIRMAN: The four Atlantic
Provinces?

DR. LANE: Yes.

DR. SMITH: We feel that this council
would help correct this gap in our chain, and would
encourage better practising of podiatry in the Eastern
Provinces. The fact that those Acts do not exist Provin-
cially is a handicap to us as we are now, but if there
was a national board or council which could supervise
this, it would, I believe, in fact we all believe, I
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Smith

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COMMISSIONER McCUTCHEON: What procedures are you authorized to do in Ontario under your Act? Can you prescribe drugs?

DR. SMITH: Yes, a limited amount. We are not allowed to prescribe narcotics, but virtually any drugs necessary for the patient's welfare.

COMMISSIONER McCUTCHEON: I am talking about drugs that can only be obtained on prescription.

DR. SMITH: Yes.

COMMISSIONER McCUTCHEON: Can you do any cutting procedures?

DR. SMITH: Yes. We are not permitted to do general anaesthesia; we can do local anaesthesia. We also have clinics in hospitals, in Toronto especially. Perhaps Dr. Gunn would care to elaborate on that.

DR. GUNN: Mr. Chairman, we have five clinics in operation here in Toronto, but we don't have enough podiatrists to staff them and the requests are coming from other hospitals who are in need of more practitioners.

COMMISSIONER McCUTCHEON: Where are your present clinics?

DR. GUNN: We have them in the Toronto General, Toronto Western, St. Michael's, St. Joseph's and Baycrest Hospital.

THE CHAIRMAN: What about Sunnybrook?

DR. GUNN: So far, not yet, sir.

THE CHAIRMAN: Can you operate under general anaesthesia in the hospital?

DR. SMITH: No, sir.

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THE CHAIRMAN: If you had to perform under general anaesthesia in the hospital you could not do so if it was necessary?

DR. SMITH: We would be happy to do so. We have our surgical procedures and if it was permissible to do that we would be most happy.

THE CHAIRMAN: You are not allowed to do so?

DR. SMITH: We hope for that eventually.

THE CHAIRMAN: Have you the right to admit patients to the hospital?

DR. SMITH: No.

THE CHAIRMAN: Only to the clinic?

DR. SMITH: To the out-patient department.

THE CHAIRMAN: What is the necessity for asking the right to admit, or is most of the work to be done, by the very nature of it, to be done in an out-patient clinic?

DR. SMITH: Not necessarily. There are cases we should refer to hospital but we are not permitted to do so.

THE CHAIRMAN: You would have to do that through the physician?

DR. SMITH: Yes. We co-operate with the physicians and surgeons very well.

THE CHAIRMAN: And in that way you get your patients into hospital?

DR. SMITH: Yes, we can do so.

COMMISSIONER STRACHAN: Do you do any

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COMMISSIONER BRADSHAW: Do you do any



Smith

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in-patient work in hospital?

DR. SMITH: If the patients or the relatives ask for it we are permitted to go to hospital and we can go into the operating room. We are not permitted to operate, but some of our surgeons are most co-operative, because after-care is very much improved by observing the surgical procedures. We have no gripe or complaint against the individuals with whom we have to work; they are most co-operative.

COMMISSIONER McCUTCHEON: I noticed the other week the brief of the Canadian Diabetic Association contained a recent copy of their magazine, The Canadian Diabetic; that on one page they were urging patients under certain circumstances to consult podiatrists. Are the diabetics one of the larger fields?

DR. SMITH: I would think it is the biggest.

DR. GUNN: In Baycrest Hospital 27% of the patients are diabetic. In the Toronto General the podiatrists on the staff there see about 12 diabetics each morning in the clinic. About 20% of the patients would be diabetics on some days.

COMMISSIONER McCUTCHEON: And I would take it that the Canadian Diabetic Association, making that recommendation - are physicians treating diabetics accustomed to referring patients to you?

DR. SMITH: A fair number do, sir. As a matter of fact, I would say that most physicians who have diabetic patients exhort those patients to be very careful in the care of the feet, not to be doing



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bathroom surgery, and if they need any work they generally refer them to us for that type of work.

As you know, our scope of service covers more than this, but that is a very important phase, and our brief states that with the increased age of the population and peripheral vascular diseases resulting therefrom, we are going to have more and more complications in the lower extremities of patients who are going to require our services.

Now, we are unable to provide those services at the moment and, as we have stated, we would like the honourable members to recommend that some effort be made on the part of the Provincial and National Government to establish means whereby we can improve those opportunities for patients requiring those services.

COMMISSIONER McCUTCHEON: Have you had any discussions with any of the universities about establishing a school?

DR. SMITH: We have had, sir. We have had discussion with the University of Toronto, the former Dean, and we get so far and then comes, of course, the all-important subject of finances, and we know this is a problem universities ---

COMMISSIONER McCUTCHEON: Yes, but leaving aside the question of finances, that really isn't the problem of the Dean, what was the attitude of the former Dean as to the desirability for that?

DR. SMITH: They are kindly disposed to this, they felt it was a gap in the medical team that

bathtub surgery, and if they need any work they
generally refer them to us for that type of work.

As you know, our scope of service

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should be adequately covered.

COMMISSIONER McCUTCHEON: You want a school in Canada, you want one school, and you may want another after that. Have you had any discussion about the cost, with large staff which, to a considerable extent, would teach the subjects which would be in your curriculum; what really would it cost to establish operating room facilities?

DR. SMITH: It is rather difficult at this stage to come out with a budget because we would have to do much more research into what facilities presently existing could be used by the podiatrists' school in the university. But we have teaching clinics; they could be used.

COMMISSIONER McCUTCHEON: You have clinics in teaching hospitals now?

DR. SMITH: Yes, and, of course, these facilities would be very adequate. For the remainder we hope to at least establish this school, and we are thinking in terms of Toronto as a locale. We feel that philanthropic funds are available for this purpose and if this were taken to that point, we would have find out or establish a point of sustaining costs.

COMMISSIONER McCUTCHEON: If, in the next three or four months, you come to any conclusions as to what you think it might cost capital-wise and operating basis to establish such a school, and if the new Dean were to give you encouragement at all, we would be very happy if you let us know in writing to the Secretary.



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Smith

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DR. SMITH: We would be most happy to do so if we could. If we could do so, it would be an encouragement, perhaps, to the university to consider.

COMMISSIONER McCUTCHEON: Do the Workmen's Compensation Board use your services?

DR. SMITH: Yes. They pay just as for a physician, the same amount.

COMMISSIONER McCUTCHEON: What about the commercial insurance companies?

DR. SMITH: A number of them do. A number pay part, a number pay the total amount, not all of them.

COMMISSIONER McCUTCHEON: I am not thinking of pay, because that would depend on the type of contract, but a number of them do recognize podiatrists?

DR. SMITH: Oh, yes.

COMMISSIONER McCUTCHEON: What about the doctor-sponsored plans?

DR. SMITH: No, sir, they do not. That is our report in the final clause, Clause 12, that we feel these services are already covered by many of those plans. There would be no additional costs, we feel, to the subscriber or should be none, because they are already paying for that coverage. It would seem, however, it is paid only in certain cases, depending on who does the job.

COMMISSIONER McCUTCHEON: Thank you very much.

THE CHAIRMAN: Well, Dr. Smith, as you see, we are quite interested in the problem.



Smith

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COMMISSIONER McCUTCHON: Thank you

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Smith

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DR. SMITH: We appreciate that, sir.

THE CHAIRMAN: And it is quite pleasing to hear of the pleasant relationships that exist between your organization and the medical profession, and what has transpired here this morning will go to Dr. McFarlane's Committee for his consideration as well. If you will follow through on the suggestion made by Mr. McCutcheon, we can see what can be done.

DR. SMITH: Thank you so much, sir. May I say thank you on behalf of our fellow members for the kindly reception we have been given.

THE CHAIRMAN: I think we will take a short recess.

--- Short Recess

MR. SMITH: We appreciate that, sir.

THE CHAIRMAN: And it is quite

pleasing to hear of the pleasant relationships that exist between your organization and the medical profession, and what has transpired here this morning will go to Dr. McFarlane's Committee for his consideration as

well. If you will follow through on the suggestion made by Mr. Hutchinson, we can see what can be done.

MR. SMITH: Thank you so much, sir.

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THE CHAIRMAN: I think we will take a

short recess.



THE SECRETARY: The next submission is that of the Interprovincial Association of Prosthetists and Orthotists of Canada. It will be known as exhibit 368, and Miss Dymond will introduce her group and the submission.

---EXHIBIT NO. 368: Submission of the Interprovincial Association of Prosthetists and Orthotists of Canada.

SUBMISSION OF
INTERPROVINCIAL ASSOCIATION OF PROSTHETISTS
AND ORTHOTISTS OF CANADA

APPEARANCES: Miss S. Dymond
Mr. H. Doyle
Dr. J.S. Crawford
Mr. G.I. Kinman.

THE CHAIRMAN: Miss Dymond.

MISS DYMOND: Mr. Hugh Doyle is an orthotist and president of the Association. Dr. J.S. Crawford is an internist, specialist in clinical medicine and Mr. George Kinman is a prosthetist and orthotist but chiefly prosthetist.

Mr. Chairman, would like me to read the whole brief?

THE CHAIRMAN: Yes. We invite you to take a chair.

MISS DYMOND:

I SUMMARY

1. The recognition of Prosthetists and

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Mr. G.T. Kinnear

THE CHAIRMAN: Miss Dymond.

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and Mr. George Kinnear is a prosthetist and orthotist but

chiefly prosthetist.

Mr. Chairman, would like me to read

the whole paper?

THE CHAIRMAN: Yes. We invite you to

take a chair.

I SUMMARY

The recognition of prosthetists and



Dymond

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Orthotists as essential workers in the paramedical field of rehabilitation is long overdue in Canada.

Recommendation: In its literature the Department of National Welfare should include Prosthetists and Orthotists either by those names or by names of Limb and Brace Makers, as members of the team assisting in the rehabilitation of a patient.

2. Many prepaid health and medical insurance plans do not provide for payment for artificial limbs or braces. Recommendation: Any voluntary National Health Insurance Plan should include in the coverage, the cost of both artificial limbs and braces.

3. There is no organized training in Canada in the field of Prosthetics or Orthotics. Recommendation: To assist in maintaining and improving the standards of the Prosthetists and Orthotists in Canada, grants should be made, either to one or more Universities or to one or more Provincial Trade Schools to encourage courses in Prosthetics and Orthotics in line with the proposed syllabus submitted herewith.

4. A state of unfair competition exists between the Department of Veterans Affairs of the Government of Canada and private industry. Recommendation: In the field of Prosthetics and Orthotics, the operation of Veterans' Hospitals should be restricted to persons qualified to receive benefits therefrom.

II This brief is submitted by The Interprovincial Association of Prosthetists and Orthotists of Canada. This Association was organized in 1955, and on November 27th, 1957, was granted Letters

Orthotists as essential workers in the paramedical field of rehabilitation is long overdue in Canada. Recommendation: In its literature the Department of National Welfare should include Prosthetists and Orthotists either by those names or by names of Limb and Brace Makers, as members of the team assisting in the rehabilitation of a patient.

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II
This brief is submitted by The Interprovincial Association of Prosthetists and Orthotists of Canada. This Association was organized in 1955, and on November 27th, 1957, was granted letters



Patent by the Secretary of State of Canada. The objects of the Association are as follows:

- (a) To consider and deal with all problems relating to the construction, fitting, adjustment and distribution of prostheses and orthopaedic appliances of all kinds and materials;
- (b) To foster equity in business methods and to promote activities aimed to enable members engaged in the fitting of prostheses and orthopaedic appliances to conduct themselves with the utmost efficiency;
- (c) To assist in improving the standards of prosthetists and orthotists in Canada and the fitting of appliances;
- (d) To assist disabled persons to rehabilitate themselves;
- (e) To disseminate information of a general economic and social character, to analyze subjects relating thereto and to secure and present the views of the members of the Corporation to other organizations and the public at large;
- (f) To secure co-operative action in advancing the common purposes of the members of the Corporation.

Membership in the Association is limited to persons deemed qualified by the Association to

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4 carry on business as Prosthetists and Orthotists. The
5 present membership is made up of the employers and
6 employees of 14 private firms carrying on business
7 either as Prosthetists or Orthotists. Five of the
8 member firms are located in Toronto, three in Montreal
9 and one each in the cities of Edmonton, Calgary,
Fredericton, Hamilton, Ottawa and Vancouver.

10 III There are between 35 and 40 individual
11 firms in the business of either Prosthetics or Orthotics
12 in Canada. The total number of persons working in these
13 businesses in private industry, is between 130 and 140,
14 and 40 of these are in Toronto. In addition to the
15 persons employed in this line of business in private
16 industry, others are employed by the Department of
17 Veterans Affairs of the Government of Canada. Sunnybrook
18 Hospital in Toronto is the central procurement, manu-
19 facturing and supply centre and there are 11 smaller
20 Prosthetic manufacturing and fitting centres at
21 Departmental District Hospitals.

22 IV Since the First World War, the use of
23 artificial limbs and braces has increased with the
24 ever increasing knowledge of the medical profession and
25 with new discoveries in the fields of materials used
26 for the necessary equipment. Highly skilled technical
27 designers, fitters and servicemen throughout Canada have
28 been assisting in the rehabilitation of people from all
29 walks of life. Through the combined stimuli of a
30 desire to serve and of private competition, the
Prosthetists and Orthotists of Canada have serviced the
health needs of the people of Canada in this particular



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member firms are located in Toronto, three in Montreal and one each in the cities of Edmonton, Calgary, Fredericton, Hamilton, Ottawa and Vancouver.

There are between 35 and 40 individual firms in the business of either Prosthetics or Orthotics in Canada. The total number of persons working in these businesses in private industry, is between 150 and 180, and 40 of these are in Toronto. In addition to the persons employed in this line of business in private industry, others are employed by the Department of Veterans Affairs of the Government of Canada. St. Mary's Hospital in Toronto is the central procurement, manufacturing and supply centre and there are 11 smaller Prosthetic manufacturing and fitting centres at Departmental District Hospitals.

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4 field of rehabilitation with the most modern products and
5 service available. Those employed in the industry in
6 Canada have banded together to attempt to raise their
7 own professional standards and to set a code of ethics.
8 The Prosthetist and the Orthotist both deal personally
9 with the patient during the course of rehabilitation and
10 the relationship between them and the patient is similar
11 to the doctor-patient relationship. Recognition should
12 be given both to the Prosthetist and to the Orthotist
13 as essential workers in the paramedical field of
14 rehabilitation and standards should be set which will
15 be applicable across Canada. Official literature from
16 all Government Departments with respect to the field
17 of rehabilitation should include the Prosthetists and
18 the Orthotists as members of the paramedical team.

19 V Although the payment for braces and
20 artificial limbs is a permissible medical expense under
21 the terms of the Income Tax Act of Canada, generally
22 speaking, most insurance plans do not cover the cost of
23 braces and only a few cover the field of artificial
24 limbs. It is felt by the Association that any national
25 voluntary insurance plan provided to cover the cost of
26 health services for Canadians must include the cost of
27 artificial limbs and braces.

28 VI There is no organized training in
29 Canada in this field. Most of the Prosthetists and
30 Orthotists are self-trained. Some have attended courses
at New York University, or the University of California in
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Courses at these Universities vary in length from two to

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four weeks with practical training in addition. They vary in cost from \$125.00 to \$200.00. Persons employed by Prosthetists or Orthotists who have been certified by The Interprovincial Association of Prosthetists and Orthotists of Canada, are given training in measurement, casting, constructing, fitting, metalwork, woodwork and leatherwork. It is felt very strongly that training should be provided in anatomy, physiology, metallurgy and mechanics by University trained personnel. The allied fields in rehabilitation such as physiotherapy, occupational-therapy, and social welfare, all receive indirect or direct assistance by way of grants to Universities. This Association recommends that in order to increase the standards of Prosthetists and Orthotists in Canada, Federal Government grants should be provided to organize courses through the University Extension Department, either at the University of Toronto, or at such other University as this Commission may deem appropriate, leading to certification as a Prosthetist and Orthotist. Such courses should provide, at night, for a period of one academic year, training in the subjects of anatomy, physiology, mechanics and metallurgy. Persons desiring to be certified as a Prosthetist and Orthotist should be required to attend such an extension course and upon the successful passing of written examinations, with respect thereto, should be required to attend 20 to 30 practical lectures which ~~could include~~ all aspects of fitting, prescription terminology, material properties, plaster of paris and specialized materials, footwear accessories and modifications, standard



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Persons desiring to be certified as a Prosthetist and
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course and upon the successful passing of written
examinations, with respect thereto, should be required
to attend 20 to 30 practical lectures which cover training
all aspects of fitting, construction technology,
various prosthetics, patterns of casts and mechanical
materials, footwear accessories and orthotics, and



braces and particular appliances, together with a course of approximately 10 lectures on clinical subjects of particular interest to bracemakers. A proposed syllabus is annexed hereto as Appendix "A". An apprenticeship with a firm approved by the appropriate Government Department for a period of 2 years should be served. It is suggested that the apprenticeship could be carried on in the daytime while the courses are being taken in the evenings. It is recommended that the basic educational requirement for admission as an apprentice be the successful completion of Grade 12, including mathematics and physics. This Association feels that once such a University course were established, abbreviated refresher courses should be arranged for those already practising as Prothetists or Orthotists, and they could be certified upon attending one such abbreviated course.

VII - Services - Under arrangements with The Workmen's Compensation Board of the Province of Ontario, with certain rehabilitation centres such as Lyndhurst Lodge, and with other Workmen's Compensation Boards throughout Canada, the Department of Veterans Affairs of the Government of Canada sells Prosthetic and Orthopaedic appliances to the persons serviced by these Boards or to the Boards or centres themselves. In setting the price of any appliance or brace sold, the Department does not include charges for overhead such as rent, insurance, office expense, and taxes to three levels of Government. As a result of the entry of the Government of Canada into the field of competition with private industry, Prosthetists in particular and the Orthotists



process and particular applicants, together with a course of approximately 10 lectures on clinical subjects of particular interest to businessmen. A proposed syllabus is annexed hereto as Appendix "A". An apprenticeship with a firm approved by the appropriate Government Department for a period of 2 years should be served. It is suggested that the apprenticeship could be carried on in the daytime while the courses are being taken in the evenings. It is recommended that the basic educational requirement for admission as an apprentice be the successful completion of Grade 12, including mathematics and physics. This Association feels that once such a University course were established, abbreviated refresher courses should be arranged for those already practicing as Prosthetists or Orthotists, and they could be certified upon attending one such abbreviated course.

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4 to some extent, are gradually being forced out of
5 business. It is felt by this Association that competi-
6 tion has kept the industry steadily advancing and that
7 the service provided by private industry is a personalized
8 service which meets the health needs of Canadians by
9 providing them with the most modern materials and
10 equipment, personally fitted, either in their homes or in
11 the hospitals, or in the office of the fitter as may
12 be needed. The Department of Veterans Affairs cannot
13 and does not attempt to go out into the patient's home
14 or homes for fitting. In many cases this service is
15 required and if private enterprise is forced out of
16 the field, it will be necessary for the Government to
17 extend its services. It has always been a principle of
18 the Workmen's Compensation Board of the Province of
19 Ontario that a patient should be free to use the services
20 of a doctor of his own choosing and it is felt that
21 this principle should extend to the related worker in
22 the field of rehabilitation, that is the Prosthetist
23 and Orthotist. If the Department of Veterans Affairs
24 were to limit its sales and services to persons qualified
25 to receive benefits from it or, if it were to charge
26 a realistic price for its sales and services to persons
27 and organizations other than those qualified to receive
28 benefits, competition would be fair and private industry
29 would be able to continue to meet the needs of the
30 people of this country.

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to some extent, are gradually being forced out of business. It is felt by this Association that competition has kept the industry steadily advancing and that the service provided by private industry is a personalized service which meets the health needs of Canadians by providing them with the most modern materials and equipment, personally fitted, either in their homes or in the hospitals, or in the office of the fitter as may be required. It is felt that the service should be extended to homes for fitting. In many cases this service is required and if private enterprise is forced out of the field, it will be necessary for the Government to extend its services. It has always been a principle of the Workers' Compensation Board of the Province of Ontario that a patient should be free to use the services of a doctor of his own choosing and it is felt that this principle should extend to the related worker in the field of rehabilitation, that is the Prosthetist and Orthotist. If the Department of Veterans Affairs were to limit the sales and services to persons qualified to receive benefits from it or, if it were to charge a realistic price for its sales and services to persons and organizations other than those qualified to receive benefits, competition would be fair and private industry would be able to continue to meet the needs of the people of this country.

Gentlemen, this is the submission of the Association. I think all three of these points would be pleased to answer any questions, and perhaps,



Dymond

12342

to add new things that have come up since the brief
was prepared.

THE CHAIRMAN: Thank you. We are
prepared to hear anything further you wish to say now.

MISS DYMOND: Mr. Chairman, could
we hear Dr. Crawford first as he is anxious to leave.



to add new things that have come up since the brief

THE ATTORNEY

THE CHAIRMAN: Thank you. We are

prepared to hear anything further you wish to say now.

MISS DYMOND: Mr. Chairman, could

we hear Dr. Crawford first as he is anxious to leave.



Crawford 12343

DR. CRAWFORD: To handling problems of locomotion. . Of course, I am very closely related to these people and I have often talked to them in the past about the problems of trying to get braces and equipment.

In Toronto, of course, we don't have as much difficulty; some of the people outside of the City have.

Part of the problem is this: That we are in a country so widely diversified, so wide-spread out, that it takes quite a bit of time to try and cover. For example, one brace maker in the City of Toronto, I don't know about the others, has to cover most of Ontario once a month to see different patients he is requested to see in different cities and bring the measurements back and make the brace in his centre and then go back and deliver the brace and carry out the fitting.

Now, what I am getting at is he is so busy doing that that he doesn't get time to stay in his own shop. That he has to do that in order to carry on and make a profit, which is one of the main reasons he is in the business. Consequently, he does not make enough money to train a man to help carry on in his shop.

I think this is fairly universal. The result is that he is able to make a living but cannot advance like he should and as he needs to advance by the work required which means that we, as doctors, do not get the entire service that we would like to have for the patient.

We get in the smaller communities a

of location. Of course, I am very closely related to these people and I have often talked to them in the past about the problems of trying to get places and

In Toronto, of course, we don't have as much difficulty; some of the people outside of the City have.

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so busy doing that that he doesn't get time to stay in his own shop. That he has to go that in order to carry on and make a profit, which is one of the main reasons he is in the business. Consequently, he does not make enough money to train a man to help carry on in his shop. I think this is fairly universal. The

result is that he is able to make a living but cannot advance like he should and as he needs to advance by the work required which means that we, as doctors, do not get the entire service that we would like to have for the patient. We get in the smaller communities a



Crawford 12344

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4 little worse than that. We can't get the equipment.
5 Can't get the fittings that we would like to see done
6 and the man carry on the training to take post-graduate
7 work in order to keep up to date. He has not got money,
8 nor time. I do feel that in Canada we have the equipment.
9 We have the personnel that we could carry on a research
10 program in the development of artificial limbs that would
11 not have to be second to anybody in the world. Britain
12 right now, and United States are carrying on extensive
13 research and we make use of all their research in our
14 limbs. Many of our fixed parts are bought from the
15 United States and bought from Great Britain and there is
16 no reason at all, if we were able to have more financial
17 backing, if money could be made available to train some
18 of these men to send them away to obtain training, we
19 could carry on a research program, develop our own
20 artificial limbs in our own country.

21 The Department of Veterans' Affairs
22 has been able to develop probably one of the best prothesis
23 in the world for hip disarticulation. We have the
24 potential here to do it. The service that we can get from
25 the private brace maker, I think, is just as good and
26 can be better than we can get from the Department of
27 Veterans' Affairs. I won't condemn the Department of
28 Veterans' Affairs, because the service for certain cate-
29 gory people is fine.

30 I would recommend that if we can get
monies made available to train these people, monies made
available for research, perhaps actual research grants
might be made available to the prothesetist, that he can

little worse than that. We can't get the equipment. Can't get the fittings that we would like to see done and the man carry on the training to take post-graduate work in order to keep up to date. He has not got money, nor time. I do feel that in Canada we have the equipment we have the personnel that we could carry on a research program in the development of artificial limbs that would not have to be second to anybody in the world. Britain right now, and United States are carrying on extensive research and we make use of all their research in our limbs. Many of our fixed parts are bought from the United States and bought from Great Britain and there is no reason at all, if we were able to have more financial backing, if money could be made available to train some of these men to send them away to obtain training, we could carry on a research program, develop our own artificial limbs in our own country.

The Department of Veterans' Affairs has been able to develop probably one of the best prostheses in the world for his disarticulation. We have the potential here to do it. The service that we can get from the private brace maker, I think, is just as good and can be better than we can get from the Department of Veterans' Affairs. I won't condemn the Department of Veterans' Affairs, because the service for certain categories of people is fine.

I would recommend that if we can get money made available to train these people, money made available for research, perhaps actual research grants might be made available to the prosthesist, that he can



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then carry on a research project to develop and make it available to people across the country.

THE CHAIRMAN: Thank you, Dr. Crawford. Anything further? Any of the others like to say anything?

MR. KINMAN: The main difficulty that we have, Mr. Commissioner, is this: That we regard it as being quite unfair competition on the part of Government, because speaking in broad general terms, they take our prices and they supply limbs or have been doing, not universally, but quite frequently at half that cost. They have an arrangement with the Workmen's Compensation Board that supplies the Compensation Board of the Province of Ontario with limbs at half price.

Now, many years ago when I was first in Ontario, we had several hundred Workmen's Compensation cases. Now they have dwindled down to those that could be counted on the fingers of your hand and are all problem cases that just refuse to go, or have not obtained satisfaction at Sunnybrook.

I personally feel that if Sunnybrook wants to enter into competition, they should charge a realistic price covering office overhead, in general that we are faced with. We pay taxes to three levels of Government. In turn we are supporting people that are in competition with us. That is one of the things.

As far as the development of limbs are concerned, in the States a million and a half dollars is set aside each year for the development of artificial limbs. Things of that nature. That is allotted to universities and others to take part, but in Canada we

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5 research that has been done is being done by private
6 enterprise, and to some extent, by the Government.

7 MISS DYMOND: Mr. Commissioner, there
8 are perhaps a few figures that should be presented. We
9 seem to be hearing a lot of figures. In the most
10 recent issue of the Dominion Bureau of Statistics the
11 figures for 1961 of artificial limbs in Canada were only
12 1,432. Now this does not include all of the Western
13 Provinces, because the return, apparently, was not too
14 complete from there, but it does include the Department
15 of Veterans' Affairs.

16 It does not include Provincial institu-
17 tions. Now, 1,432 limbs even if we are to add another
18 300 to cover the remaining Western Provinces, it can
19 easily be seen in numbers they are very few. Most of the
20 cases to date were artificial limbs required by people
21 who either were veterans or have been injured in industrial
22 accidents and are, therefore, covered by Workmen's
23 Compensation Acts or finally are children who today are
24 coming more and more under Crippled Children's Hospital,
25 Cerebral Palsy institutions, March of Dimes. Money is
26 available for them. In each of these cases centres of
27 one type and another are being set up.

28 Now, this Association feels that these
29 centres should utilize the service of the orthotists
30 and prosthetists that are available rather than setting up
a new shop where the prothesis and appliances are made in
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really doing sufficient work to justify this economically.

For this reason the Association feels some consideration should be given to means and methods of not only increasing the training, but also attempting to send the work where it is not already available.

As far as figures for braces, it's much larger, 448,200 required last year. Of these 300,000, approximately, are in Ontario and Quebec. They are far and away the largest centres for requiring braces for limbs.

I think, Mr. Commissioner, that pretty well covers the submission, unless you have any questions.

THE CHAIRMAN: What is the situation in the Atlantic Provinces? There appears to be no private industry there.

MISS DYMOND: There is, Mr. Commissioner, Menzies in Fredericton service all of the Atlantic Provinces. This is quite a large service centre, owned by father and son. Has nine employees, five of whom are disabled persons.

They service the Provinces by aeroplane. Menzies flies out where needed and takes measurements, then the people come, after the measurements are taken, to his centre. He provides room and board with hospital insurance paying for it to rehabilitate them. He does most of the work for the Workmen's Compensation Board in New Brunswick and a good deal of it for Nova Scotia.

THE CHAIRMAN: You did not list him in Paragraph 2.

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THE CHAIRMAN: You did not list him

in Paragraph 2.

MRS. DYMOND: Fredericton was not



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mentioned? It should have been, I am sorry.

THE CHAIRMAN: I am sorry, it is.

MR. KINMAN: Mr. Commissioner, may I add a few words?

THE CHAIRMAN: Indeed.

MR. KINMAN: There were in Nova Scotia one or two limb shops and also one or two have attempted to establish there. One man that I know personally was more or less promised by the Workmen's Compensation Board that he would get their business if he established in Nova Scotia. He did so, but then he was faced with trying to make limbs at prices that Camp Hill, Department of Veterans' Affairs was quoting to the Workmen's Compensation Board. Consequently, he went out of business. That is one of the difficulties that we are faced with in that place, and that is, we feel, unfair competition. Be an excellent thing for any socialist government to take this as a precedent and put any other business out of commission by simply selling automobiles, or any other things they can think of at half price. Private enterprise under those conditions would just atrophy and die.

COMMISSIONER STRACHAN: Regarding this condition, regarding the Workmen's Compensation, is this prevalent in all Provinces?

MR. KINMAN: No, sir, it does not prevail in New Brunswick, as you have just heard. Menzies does most of the work, if not all of it, in New Brunswick.

COMMISSIONER STRACHAN: At his fees?

MR. KINMAN: Fredericton establishment. He is getting a reasonable price for it. It does not

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prevail in British Columbia, very largely because the private facilities in British Columbia are closer and they are better able, not in price, but in speed to compete with the Government who has to send down to Toronto to get a lot of the appliances and limbs made so that it does not apply there.

It applies very strongly in Ontario and it applies in some of the other Provinces too. Some places you couldn't say it was 100%. I don't know exactly, we have never been able to find the exact figures from the Compensation Board, but we have made appliances for some of the Western Provinces for Compensation cases. They usually have been problem cases.

THE CHAIRMAN: Dr. Crawford, has the profession, particularly the orthotist people who deal with this, been able -- what is their situation? Were they able to deal with the private people apart from the matter of price as distinct from Sunnybrook or could encourage them in providing these artificial limbs?

DR. CRAWFORD: If I have a private patient come to my office, I cannot deal with Sunnybrook. The only way I can deal with Sunnybrook is if I have a patient who comes under the Workmen's Compensation Act of Ontario or if I have a patient that may come under the Paraplegic Association. Then I can go through this Workmen's Compensation who have an arrangement with Sunnybrook. I have no criticism. I won't say anything of the criticism of the work. Money does not enter it, as far as I am concerned but with my patient who doesn't come under those categories, then I have to deal with the man



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in the private enterprise.

THE CHAIRMAN: And he has to pay more than the other?

DR. CRAWFORD: He has to pay more than the other group. As you can see, there are many patients no doubt who largely, some way or other, come under a burnt-out pension, come under or squeeze into it some way or another to get his limbs a little cheaper.

THE CHAIRMAN: Now, the situation in Saskatchewan, as I recall it, is that the Red Cross appears to be the channel through which limbs are obtained through Sunnybrook.

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DR. CRAWFORD: Didn't Dr. Hunt bring that point out when they were presenting the Physical Medicine brief?

THE CHAIRMAN: Yes, that by some process they were able to establish a connection with Sunnybrook through one of the voluntary organizations. It may be some other organization in another province.

COMMISSIONER STRACHAN: Doctor, you use the term "a little cheaper". I gather from what others have said that it is a great deal ---

DR. CRAWFORD: I will keep out of what prices are, because in my handling of patients I keep out of the price business and suggest that they deal directly with the manufacturer of the artificial limb.

COMMISSIONER STRACHAN: For my own enlightenment what do the two groups do?

MISS DYMOND: The prosthetists make and fit, and make adjustments after fitting to artificial limbs.

COMMISSIONER STRACHAN: Upper and lower limbs?

MISS DYMOND: Yes, sir, and hands. The orthotists are brace-makers and orthopaedic appliance makers, so that they make supports for back, feet, legs, arms and all the rest of the body. They are very closely related and in many cases one firm will do both.

COMMISSIONER GIRARD: Are there any voluntary agencies that will work with you in procuring appliances for needy people, who do not come under Workmen's Compensation or Veterans?

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MISS DYMOND: In Alberta the Cerebral Palsy Association has set up its own clinic which supplies this type of person, and is also competing with private industry, bringing in people who are not cerebral palsy victims. In Ontario I believe the Department of Welfare pays the costs, the Municipal Welfare Department pays the costs of its patients, people who are already receiving welfare.

Now, I also believe that you will find throughout the country that clubs such as Rotary, Kinsmen, Lions, frequently participate.

COMMISSIONER GIRARD: These are the type I was thinking about.

MISS DYMOND: Yes, they do.

COMMISSIONER STRACHAN: Are those clubs inclined to try to get patients in under D.V.A.?

MISS DYMOND: Yes, there is one example of that at the moment in New Brunswick.

MR. DOYLE: Yes, I am afraid they do. I don't know just how.

COMMISSIONER McCUTCHEON: Have you had any conversations with the Canadian Poliomyelitis and Rehabilitation Association, the March of Dimes, with a view to obtaining training grants, or fellowships, or anything of that nature?

MISS DYMOND: I believe there have been no discussions with anyone with a view to obtaining training grants. In New York now, this is further to the brief, there is a four-year course beginning in prosthetics and orthotics.

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COMMISSIONER McCUTCHEON: Whereabouts is that established?

MR. KINMAN: New York University. A four-year course, leading to Bachelor of Science and after that course they will be expected to intern with one of the recognized and certified facilities that are actually, at present, certified by the American Board for Certification in the United States ---

COMMISSIONER McCUTCHEON: Would that be in association with Dr. Rusk?

MR. KINMAN: Dr. Rusk, yes, he is one of the leaders down there.

DR. CRAWFORD: I am on the Board of the Rehabilitation Foundation, and I suppose that if a formal application for money for, say, research or for training of, perhaps, one man, were made, that would be given sympathetic consideration and the money might be given, but I know that to carry on an extensive program, to provide the trainees, the brace-makers, artificial limb-makers that you have across the country, I don't think we could do it.

COMMISSIONER McCUTCHEON: Well, I agree, I don't think you could do it, but I mean, it might be a start for a limited amount of research centres, say, in Toronto, where a large number of your manufacturers are, or to train one or two people.

THE CHAIRMAN: Is this the type of training that you are suggesting here might be done at a technical school level?

MR. KINMAN: I don't think so, sir.



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During the past 15 years developments have been made especially in prosthetics and also in braces that have practically taken it out of the technical school level, and it is coming in more at the university level.

I think you will find that in another 10 years there will be more changes perhaps than there have been in the previous 20, and also the level will gradually be raised until perhaps those that will be practising will be probably licensed by the Board.

THE CHAIRMAN: Why is this, that you would need university training for what may, on the surface, appear to be a technical or, perhaps, mechanical calling?

DR. CRAWFORD: I think I can take the lower extremities; the University of California right now is expending tremendous sums of money to try and find out how we actually walk, the mechanism of walking, with the idea, can we develop an artificial limb that will be just as efficient as our normal leg. That requires an extensive study of anatomy and the result of their work we have made use of here in Canada to a great degree, not only in artificial limbs but in the handling of problems of pain and weakness in the extremities.

These men have to have a basic knowledge of anatomy, the functional movement.

THE CHAIRMAN: I have no difficulty in following you there, a certain number, and those who are going to be the instructors, and so forth.

DR. CRAWFORD: Well, if I have a layman



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who I want to do the fitting of an artificial leg, I want him to know the knee joint quite well, because the knee joint of the artificial leg has to be exactly the same as our normal knee joint. He has to know about the muscle, the anatomy of the hip. He has to know a little more than plain high school physics, physiology, or the working of the human body a little better.

Now, could that be taught in high school, or at the senior matric level? I would think that if doctors were asked to set up a program of training, we would make use of the university departments of physics, anatomy and physiology as lecturers.

THE CHAIRMAN: Perhaps I have not made myself plain. I am talking about the technician. There must be workers for whom this type of training would not be necessary. I can understand there are those who do the correction and so forth.

MR. KINMAN: There will always be the technician required. You can take any good leather worker and use him, provided the men at the top can give him the proper direction. You can take a good mechanic, and you can train him to carry out your orders as far as braces are concerned, and things of that kind. You can take a good woodworker and train him up to a point as far as the construction is concerned.

In other words, the point that we get at is this, and it is very closely allied: you go to a dentist for teeth, and he takes a cast of your mouth and so on, but it is very seldom that he constructs them. They go to a dental mechanic and then back to the dentist



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and he makes the adjustments and does the fitting, and I think perhaps in 10 years time a thing similar to that will happen with regard to prosthetics and orthotics.

THE CHAIRMAN: And it is for the top level that you are now speaking?

MR. KINMAN: The top level is getting higher all the time. Personally, I have taken about seven courses at university level in the last 15 years.

COMMISSIONER McCUTCHEON: This would be handled initially through Professor Williams' extension school?

DR. CRAWFORD: That is right, sir. I think that would be the place for it to be handled.

COMMISSIONER McCUTCHEON: Initially at least?

DR. CRAWFORD: Yes.

COMMISSIONER McCUTCHEON: This, of course, is the most economical way of doing it?

DR. CRAWFORD: That is right.

MISS DYMOND: I think for at least 10 years that would cover the needs by way of extension course, because in that event the not quite so top level would be able to take the course.

COMMISSIONER McCUTCHEON: Has there been any conversation with Professor Williams?

MISS DYMOND: No, there has not been conversation with anyone. This is a young Association. It had its annual meeting last Saturday in Montreal and for a three-hour meeting men came from Vancouver, Saskatoon, Fredericton, Halifax, Toronto, Montreal and



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Hamilton, for a very short time. So there is a very great interest in trying to raise the standards, and finding out what can be done, but, to date, nothing has been done in the way of practical steps to improve the training in Canada.

COMMISSIONER McCUTCHEON: Would not the first step be for the Association to try and make an impact on some of these areas we are discussing?

MISS DYMOND: They decided this at the meeting that they are going to attempt to do something with the university, but we hit again the problem of distance, and training for the people in the west and the east. Where is this going to be done? I suppose this is a problem that is applicable in every case where there is a small number of people concerned.

THE CHAIRMAN: You see, we can make recommendations and that may not be too difficult, but the working out of those is going to come right back to the areas which we are discussing here this morning, and a Commission such as this just does not spell out the workings after a statement of principle.

MISS DYMOND: No, sir, we feel that if we had the statement of principle the Association is prepared to do everything they can in working out, and the university would co-operate.

THE CHAIRMAN: You speak of research and work done in the United States that you are making full use of. Is there any idea that for climatic reasons, or any other, that we have special problems in Canada, as distinct from, say, the research work that

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is being done in California?

MR. KINMAN: Yes, sir, we do have special problems in Canada, and they have special problems also in the United States. Dr. Bector, who is pretty well-known; I was talking to him some time ago and he said: "What is the matter with you fellows in the east? You are not fitting the same percentage of certain patella tendon bearings as we are out in California." I said: "Don't you know, Doctor?" He said: "No." I said: "Well, in the east and in Canada we have more snow and winter conditions to contend with than you do in California, and for that particular reason we are not so keen on that particular type of leg." We like to feel that we are giving the best results and making the adjustment to the most suitable appliance for the case, but I mean to say, you are going to get snow and ice in the United States as well as here, but he noticed the difference between the western seaboard, shall we say, and the eastern; in percentages it showed up.



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THE CHAIRMAN: Thank you very, Miss Dymond, Dr. Crawford, Mr. Doyle.

As you see, the subject is an interesting one and an important one. We are going to give consideration to the requests that you have made, and, as Mr. McCutcheon said, perhaps your association may want to go forward on its own account in various areas, and it would appear that that is desirable, because much of what we are talking about, apart from this instruction at the higher level, and even that is in the provincial field, but the rest is definitely in the provincial field, and that this Commission can only have a limited impact on what you are asking for the future.

COMMISSIONER McCUTCHEON: Royal Commission reports are sometimes not implemented the day after.

THE CHAIRMAN: But we are grateful to you for having come here. You have brought this to our attention and, through the publicity of hearings of this kind, to a much wider area than merely being here this morning, and it is something that will have our consideration.

MISS DYMOND: Thank you very much, Mr. Commissioner, for allowing us to be here.



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THE SECRETARY: Mr. Chairman, the next submission is from Mrs. Allan Kennedy, exhibit 369. Mrs. Kennedy will come forward and speak to the submission.

SUBMISSION PRESENTED ON BEHALF OF THE
LATE DR. ALLAN S. KENNEDY

APPEARANCES: Mrs. E.B. Kennedy

---EXHIBIT NO. 369: Submission presented on behalf of the late Dr. Allan S. Kennedy.

MRS. KENNEDY: Members of the Commission,

I would like to read the introduction of this brief because it explains why I am here today.

This brief is submitted on behalf of Dr. Allan S. Kennedy, consultant in Internal Medicine, and, for the eight years before his sudden death in 1958, chairman of the Committee on Education for the Hamilton Academy of Medicine. From 1946 until he died, Dr. Kennedy was deeply concerned that the problems in medical services should not be reduced to the status of political pawns, but should be studied and solved by the members of the medical profession, the group best equipped by training and interest to arrive at wise solutions.

His respect for the sound common sense of people in all walks of life, when provided with accurate information, led him to recommend over and over



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4 again that the public should be made aware of the many
5 existing health services, aware of the great advances
6 in the field of medicine, aware of all the facets which
7 must be considered in connection with any form of
8 compulsory health insurance or socialized medicine, and
9 aware, as well, of other possible solutions to medical
care problems.

10 Dr. Kennedy's first articles for lay
11 readers were published in the Hamilton Spectator in
12 November, 1949 without a by-line. At the time of his
13 death he had embarked upon a self-imposed mission to
14 address, as a Canadian citizen concerned for the quality
15 of medical care which might be available to succeeding
16 generations, as many as possible of the men's groups in
the Hamilton area.

17 My husband would have welcomed the
18 setting up of this Royal Commission on Health Services
19 in Canada, as a means of separating FACTS from the
20 emotion-charged prejudices of OPINION, and a means of
21 lifting the entire matter out of the fog of political
22 expediency into the light of honest investigation. It
23 seems imperative to bring to your attention the
24 recommendations of one who devoted so much time and
energy to the subject now under study.

25 Other submissions will have provided
26 lists and statistics; therefore, and for brevity, these
have been omitted from this presentation.

27 1. In any puzzling situation it is
28 necessary to seek out the one crucial piece of evidence
29 which will act as the key to solving the problems
30 involved. In the confusion about medical services and



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4 how they are to be provided and paid for, Dr. Kennedy's
5 long and careful study points to this all-important
6 key-fact; medicine has made great strides since 1920,
7 and the greatest of these advances have been made in
8 countries where the government does not control or
9 direct the practice of medicine. In the United States
10 and Canada are now found the highest standards of
11 medical care and the great medical teaching centres of
12 the world.

13 2. The significance of this point is
14 inescapable. The atmosphere of democracy, with its
15 respect for the dignity of the individual, encourages
16 ideas, initiative, compassions, and courageous effort.
17 We are jolted into examining the new respect the
18 democratic ideal, which requires an informed, responsible
19 electorate and, in government, representatives who
20 exercise constant vigilance in order to maintain the
21 delicate balance between too little safe-guarding of
22 the public welfare, on the one hand, and too much
23 control for the public good, on the other. Faith in
24 this ideal has been greatly undermined by attempts to
25 distort the meaning of the term, "democracy", and
26 by a pincer attack upon its most vulnerable flank, the
27 medical profession. Ever since the end of the last
28 Great War a steady barrage of inuendo has been directed
29 against the members of the profession while the other
30 arm of the attack blanketed the populace with advocacy
of "free" socialized medicine. The doctors provided
a relatively safe target. Most of them are too busy
helping their fellow human beings to have time for verbal

for they are to be provided and paid for, Dr. Kennedy's
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of "new" socialist medicine. The doctors provided
helping their fellow human beings to have time for verbs



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4 skirmishes; the insinuations directed against them have
5 been of the sort to put them in the impossible position
6 of the man who was asked "Have you stopped beating
7 your wife?"; and the doctors could not believe that
8 their patients would be influenced by obvious untruths
and half-truths.

9 Then because of this I have gone on
10 to recommend that members of the medical profession
11 bring to the attention of the public facts and more
12 facts about medical services. These insinuations have
13 gone on and on and on, and I have seen this since the
14 end of the last World War, because that is when we
15 became aware of this. This campaign has been going on
for 40 years.

16 The next recommendation was that
17 the public be given as much accurate information as
18 possible, and there are several paragraphs in the brief,
19 three to 9, which deal with that first recommendation
20 about telling the truth about the practice of medicine
to the public.

21 Then paragraphs 10 to 15 in the brief
22 itself dwell on this recommendation that the public
23 be given a great deal more information about the angles
24 that must be considered in relation to voluntary health
25 insurance, compulsory health insurance and socialized
26 medicine. In the brief itself I have pointed out that
27 this term, "health insurance", has been a misnomer that
28 leads people to believe that this kind of insurance
29 means health, when actually it ought to be called
30 "sickness insurance" and it would help people to retain

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to recommend that members of the medical profession bring to the attention of the public facts and more facts about medical services. These instructions have come on and on and on, and I have seen this since the end of the last world war, because that is when we became aware of this. This campaign has been going on for 40 years.

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4 a sensible and realistic attitude towards these things.

5 I regret to say that a recommendation
6 which ought to have gone into this brief is not there,
7 which should follow along after the second one. That
8 is the public should be given a great deal more informa-
9 tion about the present numerous contributions by
10 governments at all levels about medical care in all
11 fields. I could list them, but I am sure the members
12 of the Commission are well acquainted with them by now.
13 The public know that hospitals for the mentally ill
14 exist, they know they can go down to the public health
15 clinic, but very few realize the vast amounts of money
16 that are being contributed by government for these
17 medical care measures.

18 Then the brief turns to the other half
19 of democracy. It points out in the brief itself that
20 if we had had an informed population, if this kind of
21 information had been given to the populace at large,
22 steadily and regularly, and I mean just the truth, facts,
23 nothing with any emotional impact at all, if that had
24 been available to the people regularly, frequently and
25 often during the past even five years, let's say ten
26 years, then the electorate at large would have insisted
27 on certain means being taken by the government. The
28 electorate has not been informed, not at all. You have
29 heard from group after group after group that everyone
30 is concerned about the poor, the old and those with
disabilities and not covered present insurance plans,
and most of these groups have advocated some form of
government insurance or socialized medicine simply because



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4 that is the only thing they have heard about. Most of
5 these groups have not shown the way to any solution
6 to this problem except that of government taking over
7 all medical care. I am sure that most of these groups
8 would have thought of this if this possibility had ever
9 been presented to them.

10 The hour is late, terribly late, and
11 I am sure something must be done about this if we really
12 care.

13 The recommendations then go specifically
14 to government in place of the electorate's demanding
15 of these things years ago, and they are these. First
16 and most obvious, that all expenses for illness and
17 sickness insurance be exempt from taxation. Any govern-
18 ment that claims to have the slightest concern for the
19 medical care of its people hasn't any right to tax the
20 money used by that person to look after his health.

21 THE CHAIRMAN: It would eliminate
22 even 3%?

23 MRS. KENNEDY: Definitely. It is
24 ridiculous to talk of being so wildly concerned about
25 medical care and then tax the money the people are using
26 for medical care. It makes no sense whatever.

27 The next recommendation, paragraph 20,
28 goes to some length to explain that people have not been
29 aware of the fact that if they pay some of the small,
30 minor illness expenses incurred by their family or
themselves the rates for their insurance goes down
drastically. Now, a family of a mother and father and
four children can be insured for \$50.00 a year, and that

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THE CHAIRMAN: It would eliminate

even 349

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4 is all-inclusive insurance, but for \$15.00 a year the
5 same family can have the same insurance coverage if the
6 family is willing to pay for the very minor items
7 themselves, and that fact is so little known. It seems
8 to me that if the government would exempt all medical
9 expenses for medical care and if anyone interested in
10 the medical care would publish this information, there
11 would be many, many more people able to keep themselves
12 free from anxiety about catastrophic illness, and that
13 is, after all, what is important.

14 COMMISSIONER McCUTCHEON: Do your
15 recommendations about exemptions apply to exemptions
16 of premiums paid to provide medical care?

17 MRS. KENNEDY: Right.
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is all-inclusive insurance, but for \$15.00 a year the same family can have the same insurance coverage if the family is willing to pay for the very minor items themselves, and that fact is so little known. It seems to me that if the government would exempt all medical expenses for medical care and if anyone interested in the medical care would publish this information, there would be many, many more people able to keep themselves free from anxiety about catastrophic illness, and that is, after all, what is important.

COMMISSIONER MACDONALD: Do you

recommendations about exemptions apply to exemptions

of premiums paid to provide medical care?

MR. KENNEDY: Right.



Kennedy

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The next recommendation is that government subsidize existing voluntary health insurance plans to the extent only that those who cannot afford and those whose disabilities now exclude them from this protection may be covered.

This is the point I was getting at a few minutes ago when I said all of us are concerned for those who are not protected. There is no one in Canada who can say, I do not care whether so-and-so gets medical care or not. The difficulty is as to how this should be done.

The only thing that has State application has been socialized medicine, compulsory health insurance. There needs to be a great deal more information about the possibility of government using existing actuarially sound agencies that are available to provide for these people. It is only a small percentage and the cost of this would be infinitesimal compared to a socialized medical scheme.

I think the reason I had 'flu so badly was one of the candidates in the present election announced to me it would be impossible because there are 450 different agencies in this part of Ontario and it would be just too difficult to work out anything like that. It would have to be all or nothing.

I guess I thought only a few days before, man's ingenuity had many applications, and intricate calculations had sent an astronaut orbiting into space. I was so ill I couldn't speak for two days.

The next recommendation is that the



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medical profession be encouraged to develop imaginative plans to solve the problem of medical care in outlying areas, with the offer of government assistance in supplementing incomes, if necessary. We do know the chief drawback to a man setting up in an outlying area is, he is so far removed from discussion with colleagues and from labs and diagnostic and treatment facilities for his patient that he feels he can't give them the kind of treatment they should have.

The other is it is very difficult for him to give his children the educational and cultural advantages that they would have if they lived in a larger centre and which he cannot afford because his income is so small in the very sparsely settled areas.

I believe C.M.A. has under consideration at the moment a very interesting and imaginative plan which might overcome one of these difficulties, and the more important one. It just needs a little climate of encouragement and of democratic impetus to put some of these things in motion.

That increasingly effective means be developed and enforced for reducing the number and severity of traffic accidents. In the body of the brief, paragraphs 24 and 25, I have discussed how wasteful it is, not only of the lives involved in the accidents but of all the hospital personnel and services. Most of these accidents could easily have been avoided. It is foolish to build more hospitals and train more people to look after accident victims who do not need to be accident victims. That is one of the largest medical problems in



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the present era. Most people treat it very casually because it is so familiar.

The last two recommendations are very general, but they are very important: in order that the public may recover a sound perspective on the field of "health" and "sickness" it is recommended that emphasis be put upon those factors which are much more basic to health, than is medical care. These are adequate exercise and rest, proper nutrition, decent housing, good working conditions and many more than you must have heard of and know yourself.

The last of all, because efforts to cloud and distort the meaning of democracy have been shockingly successful in many quarters, it is recommended that every effort be made to foster in citizens of all walks of life the concept of respect for the dignity of man which brings about mutual trust. Out of this can come the dynamic working together for the common good which is not coercion, not something superimposed, but which is democracy in action.

I would suggest that in making this business of democracy the keynote for this brief I have been following the ideas as carefully as I could of my husband. I feel that he was in the company of the greatest thinkers of all time.

A. Whitney Griswold, in 1952, addressing a large group, and at that time, President of Yale University, said this:

Man "has lived to the full the gregarious life to which half of



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his instincts committed him. And, in response to the other half, he has striven in every element on earth, in the skies above the earth and in the waters under the earth, to express himself as an individual. Philosophers have long recognized this conflict in the bosom of man and we, like every generation before us, have been witnesses to its political manifestations. Our world is divided by political philosophies which proclaim man's mechanistic fate as a species, and those which proclaim his creative destiny as an individual. At the moment the mechanistic idea seems to be in the ascendant. It is propagated at the point of the sword by dictatorships now governing nearly half the peoples of the world and seeking to extend their dominion over the rest. Perhaps never in history has the individual had to defend his birth-right against such formidable odds." Democracy "has survived because time and again it has proved, under stress, its ability to harmonize and make productive, in every sphere of thought and action, the individual



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4 and the social instincts innate in
5 man. In these respects it has demon-
6 strated its superiority over all other
7 political philosophies. All try to
8 draw the line between the opportunities
9 and responsibilities of the individual
10 and those of society, but none draws
11 it so subtly in accordance with
12 reality as democracy.

13 And what is that reality? It is that
14 for 9000 years society has depended
15 upon its members as individuals for
16 those creative achievements of mind
17 and spirit that have guided it along
18 the path of civilization. The spark
19 from heaven falls. Who picks it up?
20 The crowd? Never. The individual?
21 Always. It is he, and he alone, as
22 artist, inventor, explorer, scholar,
23 scientist, spiritual leader or states-
24 man, who stands nearest to the source
25 of life and transmits its essence to
26 his fellow men. Let them tie his
27 hands or stop his mouth or dragoon
28 him in the name of uniformity, and
29 they cut themselves off from that
30 source.

31 The Athenian statesman Pericles
32 perceived these truths when he said
33 of democracy in its earliest phase



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and the social instincts innate in man. In these respects it has demonstrated its superiority over all other political philosophies. All try to draw the line between the opportunities and responsibilities of the individual and those of society, but none draws it so early in accordance with reality as democracy.

And what is that reality? It is that for 8000 years society has depended upon its members as individuals for those creative achievements of mind and spirit that have guided it along the path of civilization. The spark from heaven falls. Who picks it up?

Always. It is he, and he alone, as artist, inventor, explorer, seafarer, scientist, spiritual leader or statesman, who stands nearest to the source of life and transmits its essence to his fellow man. Let them tie his hands or stop his mouth or dragon him in the name of authority, and they cut themselves off from that

perceived these truths when he said of democracy in its earliest phase



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that it trusted 'less in system and policy than to the native spirit of our citizens.'

This is another way of saying that democracy is fundamentally a moral philosophy, a fact which, more than any other in its nature and history, has enabled it to survive all of its previous incarnations. This is as true now in the atomic age as it was in the age of Pericles."

This ideal was so important that Mr. Jacques Barzun came all the way from Columbia to speak at Convocation Hall on three evenings to make this point very clear.

I would suggest then that thoughtful consideration will make it clear that these recommendations presented on behalf of my husband are ones which could be very easily implemented, that would have the benefit of being able to be revoked, modified, improved with experience, whereas any form of compulsory medical care is a subject which its advocates as well as opponents state is irrevokable.

Any government which refuses attention to the foregoing recommendations is thereby proclaiming its belief that Canadians are no longer capable of making a sound choice based on wide information. They are proclaiming insincerity of their professed concern for the medical care of the people, and finally and successfully, the true goal, absolute power. Thank you.



Kennedy

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THE CHAIRMAN: Thank you, Mrs. Kennedy.

It might be in order for me to say that we admire the motives which have brought you here and your devotion to the memory and ideals of your late husband and the courage it takes for a person to come forward as an individual, as other individuals have done. The sincerity of your submission is manifest, and we are indebted to you for having spoken as you have done. Your views do not necessarily coincide or harmonize with those we have heard from others, but you have pointed up here that the decision which Canada must ultimately make must necessarily be a philosophical one. We will have your submission in mind as we come to weigh and make decisions. Thank you, Mrs. Kennedy.

MRS. KENNEDY: Thank you.



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THE SECRETARY: The next submission, Mr. Chairman, is that from the Citizens Health Association. It will be known as Exhibit No. 370. Mr. MacMillan will speak to this submission.

---EXHIBIT NO. 370: Brief Submitted by the Citizens Health Association.

S U B M I S S I O N O F
THE CITIZENS HEALTH ASSOCIATION

APPEARANCES:

MR. GEORGE A. MacMILLAN.

THE CHAIRMAN: Now, if you will just take a chair, Mr. MacMillan.

MR. MacMILLAN: I prefer to stand. I feel more at home on my feet.

THE CHAIRMAN: I think perhaps it will be well if you read the whole submission. As you know, you have only sent it to us late yesterday afternoon. We have not had the opportunity which we might otherwise have had to study it, so if you will give it in full.

MR. MacMILLAN: Mr. Chairman, Members of the Commission, it was reported in the press that you wanted to hear what the general public thought about health plans as well as the views of those who operate such plans.

Since 1939, my staff and I have been listening to the health problems of people in our two

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EXHIBIT NO. 370
THE CITIZENS HEALTH ASSOCIATION

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Since 1939, my staff and I have been

interested in the health problems of people in our



MacMillan 12375

health stores. I would like to mention the fact my wife is a member of my staff. She is a graduate nurse. She was a ward supervisor in Selkirk Mental Hospital for six years.

Most of our customers are dealt with on a personal basis. We have had an opportunity to watch trends in health and in sickness and to arrive at certain conclusions.

We feel that much of the illness today is due to the fact that most people need a clearer concept of why they should try to be healthy.

Just as a person would not put anything into the motor of a car that didn't give it power or clean it, the same rule should be applied to human nutrition.

When a mother bird feels that her young ones are old enough to look after themselves, they are pushed out of the nest, and from then on they are on their own. Wild animals follow the same pattern. Nature has been following this plan with success since the beginning of time.

In the First World War the "Ladies from Hell", as the Scottish kilted troops were called, were very successful in battle because of their self-reliance. In the U.S. Marine Corps every man is trained to be self-sufficient. The Marines are sent in to win battles where it is felt other troops might fail or where they had failed.

If Canadians are going to win the battle of life, they must learn to look after themselves

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health stores. I would like to mention the last my wife is a member of my staff. She is a graduate nurse. She was a ward supervisor in Seaside Hospital for six years.

Most of our customers are of the type on a personal basis. We have had an opportunity to work with people in health and in sickness and to arrive at certain conclusions.

To feel that much of the illness today is due to the fact that most people need a cleaner concept of why they should try to be healthy.

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If Americans are going to win the battle of life, they must learn to look after themselves.



MacMillan 12376

and be self-sufficient. Otherwise, the 50% occupancy of hospital beds by mental patients will increase.

We are going to have to compete in a tougher economic world in the years to come. We will need a working force that is healthy, mentally, emotionally and physically, if we are to maintain our present standard of living. The high operating costs caused by absenteeism in industry from sickness must be reduced. Also, the high cost of social welfare.

In October, 1957, we recognized that something must be done about this situation. Our organization was formed and educational lectures were started, running from October to May during 1957, '58, and '59. Speakers were selected from the various healing professions licensed to practice in Ontario. Meetings were continued on a less frequent basis because our meeting place was the building at 54 Yonge Street, which was torn down. Early in 1960, we had to turn our attention to the fluoridation question.

We have opposed the principle of fluoridation because we feel that it is the responsibility of the individual to look after himself and his family. The community should not be expected to do something for him that he can do for himself. Dr. Leonard Larson, President of the American Medical Association, stated recently, "We believe in voluntary enterprise, in self-reliant Americans. The A.M.A. believes that a man's health needs are his own problems..."

Furthermore, we have objected to the compulsory aspect of this project. Forcing people to do



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4 things creates resentment, frustration and emotional
5 imbalance. Many communities have voted to discontinue
6 fluoridation after having had it in operation because
7 of community resentment. It creates ill feeling and
8 disunity in a community. Therefore, it will never be
9 successful as a health measure. When a community does
10 something for a person that he can do for himself, it
11 makes him soft and less self-reliant.

12 We feel that the logical course of
13 action to follow in dealing with the tooth decay problem
14 is to apply the same principle that has been used in
15 dealing with alcohol, smoking, movies and milk. We have
16 a law that prohibits the sale of alcoholic beverages to
17 minors; another law prohibits a person under sixteen from
18 smoking. This was recently enforced by the police in
19 Oakville. Persons under the age of 18 are prohibited
20 from seeing certain movies. The sale of raw milk is pro-
21 hibited because it is harmful. Also, in Toronto schools,
22 the sale of chocolate milk was stopped.

23 Since candy and soft drinks are
24 recognized as harmful to children's teeth, then why not
25 pass a law prohibiting the sale of same to them? In
26 Philadelphia the sale of sweets and soft drinks has been
27 prohibited in school cafeterias and in the school yard
28 by private vendors.

29 Another step that could be taken is to
30 lessen the dangerous effects of these products. Milk
was pasteurized to make it safer for consumption. Fluorides
or pyrodoxin could be added to candy and soft drinks to
make them less harmful to teeth.



MacMillan 12378

Returning to the general health problem, I had the pleasure of meeting Dr. T. Randolph, M.D., an allergy specialist from Chicago, while he was in Toronto recently. In his room he had this motto: "Finding and Avoiding Causes is Better than Treating Effects".

We are spending millions of dollars on training doctors, nurses, building hospitals, etc. To the best of my knowledge, nowhere in Canada is there an institution where persons can go and take a complete course on how to lead a healthy, successful life. Instead of studying diseased people we feel that really healthy people should be studied. Then their way of living should be publicized as an example for others to follow.

S U M M A R Y :

We have pointed out that people need a clear idea as to why they should take care of themselves.

We have shown that individuals would be healthier and happier if they were encouraged to be more self-sufficient and self-reliant.

It has been explained why it is necessary to keep operating costs of industry down by reducing absenteeism due to illness. Our educational activities have been outlined.

We have stated our opposition to the principle of fluoridation which is mass community care whereas people could and should look after themselves.

We have suggested that the principle of restrictive legislation as applied to problems dealing with smoking for minors, the use of alcohol and to movies

Returning to the general health problem, I had the pleasure of meeting Dr. T. Randolph, M.D., an allergy specialist from Chicago, while he was in Toronto recently. In his room he had this motto: "Finding and avoiding causes is better than treating effects."

We are spending millions of dollars on training doctors, nurses, building hospitals, etc. To the best of my knowledge, nowhere in Canada is there an institution where persons can go and take a complete course in how to lead a healthy, successful life. Instead of studying diseased people we feel that really healthy people should be studied. Their way of living should be publicized as an example for others to follow.

We have pointed out that people need a clear idea as to why they should take care of themselves. We have shown that individuals would be healthier and happier if they were encouraged to be more self-sufficient and self-reliant.

It has been explained why it is necessary to keep operating costs of industry down by reducing expenditures on illness. Our educational activities have been outlined.

We have stated our opposition to the principle of fluoridation which is mass community care. Mass people could and should look after themselves. We have suggested that the principle of restrictive legislation as applied to problems dealing with smoking for others, the use of alcohol and to movies



MacMillan 12379

might also be applied to candy and soft drinks which cause tooth decay.

We have suggested steps that could be taken to render candy and soft drinks less harmful to teeth.

We recommend that consideration be given to the idea of setting up institutions to teach people how to live normal, healthy lives. Also that the lives of normal, healthy, successful people be publicized as examples for others to follow.

That is all, sir.

THE CHAIRMAN: Thank you, Mr. MacMillan. You are a late-comer, shall we say, but nonetheless welcome to make your presentation while the Commission is still sitting.

COMMISSIONER McCUTCHEON: Mr. MacMillan, you refer to two health stores. What are these health stores?

MR. MacMILLAN: They are located here in Toronto, sir.

COMMISSIONER McCUTCHEON: What is a health store? I know what a drugstore is.

MR. MacMILLAN: It's called various names by various people.

COMMISSIONER McCUTCHEON: What do you do?

MR. MacMILLAN: We sell appliances, such as juicers, special dietary foods. Some herbal products and allergy foods and a large number of our patients are referred to us by various professions for



MacMillan 12380

special products.

COMMISSIONER McCUTCHEON: You are in the commercial enterprise, then? You are not providing health service?

MR. MacMILLAN: No, we deal with approximately forty thousand people a year at the present time.

COMMISSIONER McCUTCHEON: The Citizens Health Association, I see it was established in 1957. You are the President. How many members, roughly, in the Association?

MR. MacMILLAN: There are roughly about 250, the majority of which are my own customers.

Actually they requested this be done. They wanted more information than we could give to them over the counter at our stores and so this developed from that.

COMMISSIONER McCUTCHEON: What information do you provide to them? What type of information do you provide?

MR. MacMILLAN: The speakers at our meetings have been doctors, dentists, osteopaths, chiropractors. Anybody who is licensed to practise in the Province of Ontario. I don't speak myself.

COMMISSIONER McCUTCHEON: You have no publication?

MR. MacMILLAN: No, we haven't so far.

COMMISSIONER McCUTCHEON: And I notice that your meetings have been less frequent in recent years?

MR. MacMILLAN: Yes.



MacMillan 12345

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COMMISSIONER McCUTCHEON: Now, you say in 1960, you had to turn your attention to the fluoridation question. You say "we have opposed the principle of fluoridation because we feel that it is the responsibility of the individual to look after himself and his family."

Do I take it from that statement and a subsequent statement you made about compulsion, that you accept the findings of the Morden Commission and the statements that have been made by every Medical Association, every Dental Association that has appeared before us that one part in a million fluoride in water effectively reduces the incidence of dental caries, particularly in children?

MR. MacMILLAN: No, we do not, sir.

COMMISSIONER McCUTCHEON: Well then, if you do not, why do you recommend the introduction of fluorides in candy and soft drinks? I did not ask you whether you were in agreement that fluorides should be put in water. I asked you whether you accepted the findings that if I put one part in a million in every glass of water I drink, or if I put in my children's water, let's say, that I would have a beneficial effect on reducing dental caries?

MR. MacMILLAN: It might, in some children, depending how much water they drink.

I was present during the two weeks of the Morden Commission Hearings. I have also been to Brantford and no mention has been made at all of the oral hygiene program in Brantford, and if you go back in the 1954 report, the Department of National Health have a



MacMillan 12382

table 11 they show in there and it is 50% better than the other two committees they were studying.

By that method alone you can reduce tooth decay 60% and also we are not told that in Brantford they spend as much as \$24,000.00 a year on free dental public school service.

COMMISSIONER McCUTCHEON: That is fairly common in Ontario communities.

MR. MacMILLAN: I am talking in proportion. 45¢ a head.

COMMISSIONER McCUTCHEON: I would think that they would spend that much here. I want to see what your position is.

MR. MacMILLAN: We also feel that even if you put it in the water, many children do not drink water, for one thing. There is a wide variation in the consumption of water by children.

COMMISSIONER McCUTCHEON: It's water that goes into soft drinks.

MR. MacMILLAN: They won't put it in there. They take everything out.

COMMISSIONER McCUTCHEON: Do you think they take it out of soft drinks?

MR. MacMILLAN: They can take it out and buy a water softener now, they will take it out too. One of our customers was in yesterday. He is in the water softener business, getting a lot of requests from around the Oshawa area and Whitby. Oshawa has had it in for a good many years.

COMMISSIONER McCUTCHEON: I want to



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to 20% decay 80% and also we are not told that in Bradford

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MacMillan 12383

know what your position is. You do not accept the findings of the Morden Commission. Is that right?

MR. MacMILLAN: Yes, sir.

COMMISSIONER McCUTCHEON: You do not accept the views of the various dental associations; is that right?

MR. MacMILLAN: Right, sir.

COMMISSIONER McCUTCHEON: You do not accept the views of the Canadian Medical Association and the various Provincial Medical Associations; is that right?

MR. MacMILLAN: Yes, sir.

COMMISSIONER McCUTCHEON: That takes care of that. I am a little puzzled. You refer to your objection to compulsion. "Many communities have voted to discontinue fluoridation". I take it by that you mean fluoridation of communal water supply?

MR. MacMILLAN: Yes.

COMMISSIONER McCUTCHEON: "After having had it in operation because of community resentment." What are these communities?

MR. MacMILLAN: I can give you a list. There is quite a list of them.

COMMISSIONER McCUTCHEON: I would be very happy if you would subsequently furnish the Secretary in writing with a list showing, in addition, when the system was put in.

MR. MacMILLAN: I can cite two -----

COMMISSIONER McCUTCHEON: And when it was discontinued.



MacMillan 19383

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MacMillan 12384

MR. MacMILLAN: --who have discontinued because of corrosion in their water pipes.

COMMISSIONER McCUTCHEON: That is not what you said. I want to know. You just give me a list and tell me the circumstances.

MR. MacMILLAN: That is part of the community resentment.

COMMISSIONER McCUTCHEON: Send it to the Secretary. I am a little puzzled about your views on compulsion. Fluoridation of water is compulsion which is resented but putting fluorides or pyrodoxin into candy and soft drinks, which you recommend, is not compulsion. Is that right?



Macmillan 12344

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MacMillan

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MR. MacMILLAN: Well, they can put two types of products out. For instance, you can buy whole milk or homogenized.

COMMISSIONER McCUTCHEON: But I cannot buy unpasteurized milk.

MR. MacMILLAN: In parts of Canada you can.

COMMISSIONER McCUTCHEON: Not in this province.

MR. MacMILLAN: No, not here.

COMMISSIONER McCUTCHEON: Very few parts. You are opposed to the pasteurization of milk?

MR. MacMILLAN: No sir.

COMMISSIONER McCUTCHEON: I see, but that is compulsion though.

MR. MacMILLAN: But I don't have to drink milk. There are a lot of people who cannot drink milk, and there are a lot of mothers today who must give their children soya products, because they are allergic to milk.

COMMISSIONER McCUTCHEON: I think I understand that. Just one more question. You would be prepared to prohibit the sale of candies and soft drinks to children?

MR. MacMILLAN: Yes I think so.

COMMISSIONER McCUTCHEON: That is not compulsion?

MR. MacMILLAN: No, it is not, because you are not compelling them to take something.

COMMISSIONER McCUTCHEON: You are



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6 a great many years.

7 MR. MacMILLAN: You are compelling them
8 to do without something which is considered harmful.

9 COMMISSIONER McCUTCHEON: I don't
10 consider it harmful.

11 MR. MacMILLAN: The dentists, at their
12 exhibit last year at the Canadian National Exhibition ---

13 COMMISSIONER McCUTCHEON: I was
14 referring to these other products which were prohibited
15 for some years. I don't eat candy.

16 MR. MacMILLAN: Well, I don't eat
17 candy if I don't want to.

18 THE CHAIRMAN: Thank you very much
19 again Mr. MacMillan. Your brief will go in the record,
20 and it will be dealt with all in due course with the
21 others that we have received.
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THE SECRETARY: Mr. Chairman, the next submission is a private submission from Dr. McGillivray and it will be exhibit number 371, and Dr. McGillivray will come forward and present his statement.

---EXHIBIT NO. 371: Submission of Dr. J.W. McGillivray.

SUBMISSION OF

DR. J. W. MCGILLIVRAY

APPEARANCE: Dr. J. W. McGillivray

THE CHAIRMAN: Again you have a short brief, and it might be as well if you read it all, if you will.

DR. MCGILLIVRAY: I will be pleased to do so.

Mr. Chairman and Commissioners: This submission is divided into two parts.

1. The Doctor-Patient Relationship.
2. A simple Medical insurance scheme.

Part One. The Doctor-Patient Relationship in private practice under the FEE-for-Service arrangement.

Stripped to its economic bones the doctor-patient relationship is the relationship of a servant to his master. The doctor is the servant and the patient is the master. These economic bones may contain the intestines of Pity, a heart of Love, and a brain of Science. They may be clothes with muscles of Strength and skin of Antisepsis, if not of Purity. The

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resulting figure may wear a breastplate of Righteousness and a cloak of Secrecy. The basic skeleton is economic.

As long as the patient pays the doctor he will remain the master and the doctor will remain his servant. As master, the patient will have a measure of control over the service rendered. If a government pays the doctor then that government will inevitably take the place of the patient as master and the doctor will become the servant of the government. In the event of a conflict of interest between his Patient-Master and a government a doctor will resolve that conflict in favour of his patient. In the event of a conflict of a patient between a patient and a Government-Master a doctor, after conflict perhaps, would tend to resolve that conflict in favour of his Government-Master. There is no such thing as a Patient-Master and a Government-Master at the same time in any given situation for as the Scriptures state "A man cannot serve two masters."

I submit that it is of the greatest importance that the People be allowed to keep their liberty. If the people are to keep their individual liberty in health matters I submit that it is necessary that they retain the individual responsibility of paying their doctor, who is also their servant, for the services which he performs.

Part Two.

A Simple Medical Insurance Scheme whereby a Government, if it is thought wise, could assume a significant fraction of the Medical and Surgical fees of the People.



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At the outset I must state that, to my knowledge, this plan has never been put forward by any political party although a vaguely similar plan has been put forward by one party.

This plan has several distinct advantages.

1. It requires a minimum of paper work and a negligible increase in the Civil Service.
2. It maintains the control of the patient over his doctor and therefore over the amount and quality of medical service which he receives.
3. It encourages thrift on the part of the patient, honesty on the part of the doctor and fairness to both on the part of the government.
4. It can be manipulated by government in any way which may be thought wise without significant dislocation of the present high standard of medical care. This is provided that the basic principle of the plan is not altered.

This, like all other medical plans has one distinct defect. It is amenable to political expediency. An overly generous government can give the people such a health plan that it would have to take away the people's liberty to control it, in order to avoid a catastrophe to the Budget.

Principle. The economic security of this plan is based on the well known slogan "Fair Shares For All". A good partnership is a fifty-fifty partnership.

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4 This plan is predicated on the idea of a fifty-fifty
5 partnership between the citizen and his government.
6 Minor variations of the proportions of this fundamental
7 partnership may be made in the case of special groups such
8 as the indigent, the unemployed, the marginal income
9 group, and the victims of catastrophe. If kept within
10 reason, the special treatment of these special groups
11 would not destroy the inherent stability of the plan.

12 The Plan. This simple plan requires
13 only the patient, the doctor, the doctor's receipt pad,
14 and the Income Tax Department.

- 15 1. The doctor serves the patient as at present.
- 16 2. The patient pays the doctor.
- 17 3. The doctor gives a receipt for the money
18 received.
- 19 4. The patient sends his receipts with his yearly
20 Income Tax Form.
- 21 5. The Income Tax Department gives the taxpayer
22 credit for 50% of the total receipts, and
23 either deducts this amount from the TAX PAYABLE
24 or, if no tax is owing, it sends a REFUND
25 for this amount to the taxpayer.

26 It will be obvious that this plan
27 could be instituted by merely amending the Income Tax
28 Act. It could be as easily altered or withdrawn.

29 There are many questions about this
30 plan which I can answer if I am asked. There is one
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not allow the doctors to inflate their fees above the
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4 expense of the people and the Income Tax Department?

5 In answer I must point out that the
6 plan, as outlined, does not represent a radical departure
7 from the present situation in which medical fees bear
8 a fairly definite relationship to their fair market value
9 and to the income which patients have to dispose of after
10 providing for such necessities as food, clothing, shelter,
11 alcohol, and tobacco. Furthermore the average doctor
12 returns to the government 40% of his taxable income over
13 \$12,000.00 and 45% of his taxable income over \$15,000.00.
14 Inflation of a doctor's income would be counterbalanced
15 by the understandable reluctance of the patient to pay more
16 than the fair market value for service received. The
17 Department of Internal Revenue would be further
18 protected by the fact that doctors with top incomes
19 would pay, in Income Tax, sufficient money to give the
20 refund to the patient at no cost to the Treasury. The
21 patient meanwhile would receive his medical care at 50%
22 of the fair market value.

23 Summary. I submit that under the
24 system of medical practice which is usual in this country
25 the doctor is the servant of his patient in an economic
26 sense. I submit that this system is good for the
27 patient as well as for the doctor. I submit that it is
28 of fundamental importance to the continuance of this
29 master-servant relationship that the master be directly
30 responsible for paying his servant. I have submitted
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McGillivray

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5 THE CHAIRMAN: Thank you Dr. McGillivray.
6 You are practising here in Ontario?

7 DR. MCGILLIVRAY: Yes sir.

8 THE CHAIRMAN: How long have you been
9 practising Doctor?

10 DR. MCGILLIVRAY: I trained in surgery
11 in Toronto, sir, for five years. I have been in practice
12 in Orillia and Collingwood for four years in addition.

13 THE CHAIRMAN: On page one you
14 interest me with the proposition of the master-servant
15 relationship that you put forward, and would I be right
16 in accepting that the basis of your submission here,
17 insofar as page one is concerned, is that this relation-
18 ship is one of master and servant?

19 DR. MCGILLIVRAY: Yes sir.

20 THE CHAIRMAN: And that if that should
21 not be the case, then the argument collapses?

22 DR. MCGILLIVRAY: Not necessarily,
23 but it is germane to the subsequent problem. You might
24 say -- well, the argument would be weakened. I would
25 say that.

26 THE CHAIRMAN: Would you accept the
27 view that I might suggest now that that is not the
28 relationship in law between the doctor and the patient?

29 DR. MCGILLIVRAY: I don't know the
30 law sir. I am suggesting that this is the relationship
in fact. That is to say, the doctor, if he gives
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not be the case, then the argument collapses?

DR. MCGILLIVRAY: Not necessarily,

but it is germane to the subsequent problem. You might

say -- well, the argument would be weakened

say that.

THE CHAIRMAN: Would you accept the

view that I might suggest now that that is not the

relationship in law between the doctor and the patient?

DR. MCGILLIVRAY: I don't know the

law sir. I am suggesting that this is the relationship

in fact. That is to say, the doctor, if he gives

unsatisfactory services in any way, the patient may say



McGillivray

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2
3 him: "Thank you, goodbye".

4 THE CHAIRMAN: That is quite true.

5 DR. MCGILLIVRAY: And he may get a
6 new doctor and a better doctor, or a more suitable
7 doctor, if he wishes.

8 THE CHAIRMAN: Or a poorer one.

9 MR. MCGILLIVRAY: Or a poorer one, but
10 it is up to the patient. The patient hires you, asks
11 you for advice, asks you to do something for him, asks
12 you to come to his house, or whatever may be, but you
13 come there not as a hewer of wood or a drawer of water
14 perhaps, but you come as his servant only.

15 THE CHAIRMAN: I am not going to argue
16 the point with you doctor. I am just going to suggest
17 to you that the relationship is a contractual relation-
18 ship of independent agents, independent individuals,
19 entities, and not the vertical position of master and
20 servant, and that if you accepted this, I mean if the
21 profession, if it would come to the day where they
22 would accept the proposition of the master and servant
23 relationship, I think a lot would be gone from the
24 independence of the profession.

25 DR. MCGILLIVRAY: But a good servant,
26 sir, gives good advice, whether the master likes it or
27 not, and we frequently give advice which is not
28 acceptable to our patients.
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THE CHAIRMAN: We are not going to discuss it with you; it is a matter of terminology, call it what you like. But once you predicate a proposition on the factual situation which doesn't exist, as you said at the beginning, it weakens the whole structure, does it not?

DR. MCGILLIVRAY: It would.

THE CHAIRMAN: Your proposition about the repayment of income tax; have you any idea what this would amount to in millions of dollars per year, your proposition on page 3, No. 5, top of page 3?

DR. MCGILLIVRAY: I cannot give it to you in millions of dollars, sir. I understand that there were - one could multiply the number of practising physicians in Canada by the average, which is approximately \$15,000, and come to an approximate figure.

THE CHAIRMAN: Well, if you have \$15,000, then you have, say, 18,000 practising doctors.

DR. MCGILLIVRAY: Well, I thought there were only 12,000 had any taxable income, sir. So that the others are probably salaried employees in some respects.

THE CHAIRMAN: The figures we have of practising doctors in Canada are 17,900.

COMMISSIONER STRACHAN: That is gross income.

THE CHAIRMAN: No, taxable.

DR. MCGILLIVRAY: I have never been able to be sure of that from the Canadian Medical Journal.

THE CHAIRMAN: Total receipts.

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DR. MCGILLIVRAY: Yes.

THE CHAIRMAN: Now, just to follow the thing along in a very practical sense, what happens to me if I have had to pay out \$200 or \$300 in a year for medical services but I make no income tax return?

DR. MCGILLIVRAY: Well, it is your option, sir, but you must make an income tax return if you have a taxable income. If you do not have a taxable income you fill out the form, attach your receipts with a paper clip, send them in and they will send you a refund for half, according to my plan.

THE CHAIRMAN: Do you know how many people in Canada do not send in any income tax returns?

DR. MCGILLIVRAY: In the press I read that one-third of families do not have a taxable income.

THE CHAIRMAN: Some several million people.

DR. MCGILLIVRAY: Yes. They would be grouped in families. I would have my receipts for my children and my wife. It would be an increase, but compared to the increase with a national health plan on any other principle I can think of, it would be negligible, compared with any other national health plan.

You see, we state each visit each month; doctors send in their service plan, P.S.I., a card with the policy number, group number, the name and age of the patient, the dates of the visits, the types of service and the doctor's signature. This is only in the doctor's office and perhaps doesn't concern



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the Government, but we hire secretaries to do this for us. Compared to this, all my plan would require would be a statement of how much money the patient paid and it wouldn't matter whether it was the 1st of January or the 31st of December and it wouldn't matter what the complaint was or what the treatment was, but if the patient was satisfied with it the Government would then share half the cost.

THE CHAIRMAN: The Federal Government, the income tax collected by the Federal Government?

DR. MCGILLIVRAY: I understood the provinces were returning again to their share of income tax. It could be done by any government that collects income tax and wishes to do it.

THE CHAIRMAN: You don't make a deduction from the tax instead of a deduction from the taxable income?

DR. MCGILLIVRAY: At present, your over 3% is a deduction from the taxable income. A deduction from the tax gives the taxpayer more money back which is a desirable thing. But in the meantime, the population as a whole shares half of the medical expenses of the individual. You see, if this is taken off the taxable income, then the only amount that the taxpayer saves is the top level of the tax he pays, 19% or 30%.

COMMISSIONER McCUTCHEON: It might be 70%.

DR. MCGILLIVRAY: There are not many of us who pay 70% on top of our taxable income.

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THE CHAIRMAN: On your basis you say 45%.

DR. MCGILLIVRAY: The doctors, yes. But I think it is somewhere about \$200,000 before you pay 75%. But with this plan the Government would win, would get more back, more from the taxpayer, anyway, than they would pay back to the people in the 75% bracket.

COMMISSIONER STRACHAN: Mr. Chairman, there are two things I find difficult to appreciate. What about the patient who could not pay his physician? And another thing, would it not be possible for half the medical bill to become catastrophic to an individual?

DR. MCGILLIVRAY: I have considered that problem. The individual who could not pay his physician by any measure that is agreeable to government could be handled in two ways. One is that they could continue to be looked after under the medical welfare plans that are now in operation in Ontario and in the other provinces. They are a special group of people who have essentially nothing but old-age pension and mother's allowances. They could then be separated from this.

The other way that they could be looked after would be that one would take the attitude that after a service is given, if they could not pay for it, the doctor was charging them too much, it is part of the code of ethics of the Royal College of Physicians and Surgeons in Canada that, with respect to any given service, the value of it depends, first of all, on the

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value of the service and, secondly, on the patient's reasonable ability to pay, and the patient shall receive the service first and the doctor would not receive the money. And thirdly, if those who are not satisfactory, the Government could force specified individuals to arrange to purchase a plan, P.S.I. or M.S.I.

COMMISSIONER STRACHAN: Then you would be into compulsion.

DR. MCGILLIVRAY: No, sir. Who would be compelled?

COMMISSIONER STRACHAN: I thought you said compel.

DR. MCGILLIVRAY: No, for people who could not pay the Government would have the option of giving them this plan.

COMMISSIONER STRACHAN: Would it not be possible for even half of a medical bill to be a catastrophic matter for the patient?

DR. MCGILLIVRAY: Yes, sir, it would. Not nearly so much as one would be led to believe by stories that we hear. But supposing a medical bill amounted in one year, say, to a thousand dollars, this would be catastrophic to most people. I am sure we would all agree with that. If this were to be altered - and I have left out the details, Mr. Chairman, in hope of making it clearer - this could be altered so that all the bills above a specified limit, say, five hundred dollars in a year, or it could be less, all the bills above that would be refunded. If a patient had a thousand dollars of medical bills, and this could include



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dental, the osteopathic, chiropractor, special nurse, hospitals, ambulances, anything they wished to be included in this plan, he could receive a half of the first 500 dollars and 100% of the second 500 dollars and the citizen would be obligated to pay \$250, which, for some people, may be catastrophic, but for most people it is not.

THE CHAIRMAN: It is close to the result in Australia at this stage.

DR. MCGILLIVRAY: The Australian plan is 90%; the Swedish plan is, I believe, 75%.

COMMISSIONER McCUTCHEON: You are not necessarily advocating a plan, are you?

DR. MCGILLIVRAY: Not many people have a plan. If we can have one, have one that we can afford, and if it costs so much the Government can manipulate it so that they only pay 40%.

THE CHAIRMAN: You intrigue us, Dr. McGillivray. You have put forward a plan which may not be economically, as a matter of reality, feasible. But you are one of those people for whom we have admiration; you have sat down and thought about it, and if we have more people in Canada thinking about it and coming forward with ideas, it will be much better for everybody.

DR. MCGILLIVRAY: This plan would not infringe on anybody's liberty.

THE CHAIRMAN: We will study it. I have only one suggestion I am going to make: when you leave here today, don't stop thinking. If you have some other ideas on this, send them to us.

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DR. MCGILLIVRAY: Thank you, sir.

THE CHAIRMAN: Thank you.

We will adjourn till 2 o'clock.

--- Luncheon adjournment.



12401

THE SECRETARY: Mr. Chairman, the first submission is from St. Michael's Hospital. It will be Exhibit 372. Reverend Sister Janet will introduce her group and speak to the brief.

SUBMISSION OF
ST. MICHAEL'S HOSPITAL

---EXHIBIT NO. 372: Submission of St. Michael's Hospital.

APPEARANCES:

REV. SISTER M. JANET
DR. W. KEITH WELSH
DR. E.F. BROOKS

REV. SISTER JANET: Mr. Chairman, I would like to introduce Dr. E.F. Brooks, the Chairman of the Medical Advisory Board of St. Michael's and Chief Physician and Dr. W. Keith Welsh, Chief Surgeon of St. Michael's Hospital.

Honourable Sir:

You have asked us for information concerning the utilization of hospital facilities in this province and the relative need for active, convalescent and chronic beds, and rehabilitation facilities.

There has been a tremendous change in our attitude towards hospitals in the past twenty years. No doubt there are several reasons for this change. Probably the most outstanding one is the development of hospital



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Rev. Sister 12402

and medical care. Formerly a place for the poor to die, the hospital has now become a skillfully managed centre of scientific and intelligent care where well-qualified doctors do all within their power to restore their fellow human beings to a healthy, productive life. Such a centre then, must be available to all who may have need of it. Naturally the cost of rendering this scientific service is high. As sickness may strike any of us, rich or poor, high or lowly, there follows the need of some form of insurance to protect our citizens in the case of catastrophic illness or to provide the hospital with sufficient funds to render the necessary service. These two factors - the development of hospital care and the introduction of hospital insurance - convinced the people that hospitalization was available and that it was available to each individual. A hospital is now the place to go if sickness strikes. Consequently, the improvement of hospital care and the philosophy of its availability have given rise to the high utilization rate of hospitals in our day.

The decision as to who needs a hospital bed lies with the physician who is caring for the patient. He makes the arrangements with the admitting officer and he discharges the patient when he is ready to return to his home. The hospital depends entirely on the physician's judgement and we can say that we are seldom disappointed in his assessment. However, because of the present-day attitude towards hospitals and the sense of security derived from the fact that your dear one is safe and sound in hospital, our doctors are exposed to

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Rev. Sister 12403

tremendous pressures to arrange for the admission of many borderline patients. In the doctor-patient relationship, it is extremely difficult to resist these pressures. Nevertheless, in our situation, we are convinced that there is no abuse of hospital beds.

During this past winter our hospital has been very crowded. Our policy has been not to set up extra beds and when it is absolutely necessary, to take them down the next day. However, over the past four or five months there have been very few days when we did not have extra beds in our sunrooms. We cannot trace this to anything but the greater need for beds. During January and February, the average daily admissions through the Emergency Department were fourteen - i.e. fourteen people who came from the streets or from their homes without previous medical consultation needed hospital care.

Over and above these admissions would be emergency admissions requested by doctors for patients who had consulted them in their office. We have a large out-patient clinic in which our doctors may see approximately two hundred patients a day. Frequently, some of these need immediate admission. Consequently, we need a high daily turnover to take care of our elective bookings and emergency admissions.

How long do the patients stay in hospital? The average days stay, 1960 and 1961, was thirteen days. We do not consider this a high average. Why? Let us consider some of the various illnesses we may be treating. If a patient suffers a coronary thrombosis, he must have complete bed rest for at least four weeks. If he undergoes neurosurgery, cardiac surgery,

therefore pressure to arrange for the admission of many bordering patients. In the doctor-patient relationship, it is extremely difficult to resist these pressures. Nevertheless, in our situation, we are convinced that there is no abuse of hospital beds.

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Rev. Sister 12404

orthopaedic surgery, etc., he may require anywhere from three to six weeks' stay. Many patients require at least three weeks' stay after various forms of general surgery. These stays are estimated on the presumption that the patient follows an uneventful post-operative course and do not take into consideration complications of any kind. Actually the advances in medical science are in the main responsible for lengthening our average days stay.

There are a few problems in relation to length of stay which we should consider. In our day, we are living much longer. Often when illness strikes our senior citizens, it leaves them debilitated and no longer self-sufficient and independent as they were before. If they have been living alone, or with others in the same age bracket, they cannot return to their home. Consequently, arrangements must be made for them to go to a Home for the Aged. This entails a great deal. First of all, the patient must be examined by the physician representing the Department of Welfare and Housing. If he recommends a Home for the Aged, the necessary forms must be completed. These are then forwarded to the Board which decides admissions. All this requires some two to three weeks. Often it happens that the Board does not support the physician's decision and the application is rejected and then we must start again. We consider these long delays one of the major causes for waste of hospital beds.

Another problem is the arrangement of transfer to the chronically-ill hospital and the convalescent



Rev. Sister 11/1/54

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Rev. Sister 12405

hospital. Often the waiting period is long. We anticipate that the Riverdale Hospital presently under construction, will do a great deal towards solving this difficulty. It is difficult to assess how much more efficient we would be if convalescent, chronically-ill and geriatric beds were readily available to us. Probably ten percent more efficiency would be a fair estimate.

We have two methods by which doctors may arrange for admission for their patients. The first method consists of granting a definite admission date. Approximately six weeks before the first of any given month, the bookings are opened. Each doctor attached to our hospital is contacted and admission dates assigned to his patients who he knows need hospital care. Probably some 376 patients would be booked. The name of any patient who needs admission after this date and in the doctor's opinion cannot wait until the next month's bookings, is put on the waiting-list.

On April 10, 1962, we had the names of 560 patients on this waiting-list (our total capacity is 802 beds). Of these 235 were on a list commenced around the end of January and 286 were patients attending our out-patient clinic. Because of the large number of emergency admissions, it is very difficult to reduce this waiting-list. Besides the great deal of hardship this long waiting period puts on the patient, this situation is detrimental to the teaching carried on in the hospital. We are not able to control the number of patients admitted to the various services. For this reason, the experience for postgraduate students in ophthalmology and otolaryngology and other specialties may be greatly curtailed.



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Rev. Sister : 12406

Although we have stated that in our opinion, there is little abuse of hospital beds and that we are confident our doctors are prudent and discerning regarding the patients for whom they seek admission, however, we have one problem in this line. Frequently, our senior citizens will be admitted to hospital when they could be as well cared for at home. One cause of this is the great sense of security our society feels when their relative is in hospital. Another cause is often that there is no one at home competent to take care of the patient. It is difficult to find a solution to this problem. True a visiting nurse would be of great assistance but the greatest anxieties and fears are associated with the night hours.

Are patient days wasted because of staffing problems? This might very well be true. It has been said that a hospital has three work days every twenty-four hours and this for seven days a week. We are living in the society of a five-day week which is striving for an even shorter work week. In order that our hospital may function at full capacity six days a week and at a somewhat reduced tempo on the seventh day and that all members of our staff may enjoy a five-day week, it is necessary for us to have sufficient staff to maintain the necessary level throughout the six days in spite of some members being on days off. If we could obtain sufficient personnel to staff our radiology and laboratory departments in this way, we could expedite pre-operative investigation and reduce hospital stay.

To what extent are we using our



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To what extent are we using our



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diagnostic services, the X-ray and laboratory tests?
Is there a greater use of them now than before the introduction of government sponsored hospital insurance? Once again it is extremely difficult to have a true answer. No doubt when each test meant another charge for the patient, the doctor stopped to think twice before ordering a borderline examination. But who is to estimate the number of times this was a costly economy for the patient? Now that the monetary threat is removed, the doctor can be guided solely by the need of the patient in ordering treatment and tests. There is an increased use of X-ray and laboratory procedures but we are not convinced that there is abuse. More and more are we able to obtain accurate information about the patients' illness and then to apply more specific and helpful treatment.

There has been much discussion on the advisability of extending the insurance coverage to diagnostic outpatient services. The hope is that preliminary investigation could be made while the patient remained at home and when the diagnosis was ascertained, the patient would be admitted to hospital for treatment. There is little doubt in our minds that this would result in reducing the length of stay and consequently making better use of our hospital beds.

Our hospital care is expanding and improving. We are living in an era of specialization in which our hospitals are not an exception. To improve diagnosis and treatment, we are planning such special care units as acute respiratory, cardiac, neurological, metabolic, and intensive care. Each sub-specialty is looking for its own department. There are many advantages

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to specilization - more accurate assessment, more competent nursing care, and finer medical care. There seems little likelihood that we can prohibit this steady advance. But all this is expensive and costly - yet they must be available to all our citizens according to their needs. Our challenge is to encourage these great developments and make them available to all in an efficient and economical way.

Thank you.

THE CHAIRMAN: Thank you very much, Sister Janet. I want to thank you on behalf of the Commission for having accepted our invitation to come here at this time and to give your answers to the specific and somewhat less specific questions that were posed in our letter to you of March 12th on the topics that you dealt with, namely the use of the hospital beds and the length of stay of patients, waiting periods until admission, beds not used for various reasons and any other relevant information on the subject of making the most effective and efficient use of hospital facilities, beds operated for diagnostic service and so forth.

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THE CHAIRMAN: You have compiled this in the form of a running story; posing the question and answering it in turn. Perhaps the only question that I did not see dealt with is the one dealing with operating rooms. In that respect, are the operating theatres in the hospital used seven days a week?

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REV. SISTER JANET: No, Mr. Chairman, they are not used electively seven days a week. They are used in emergency when they are needed. There again that staffing problem comes in. For instance, on Saturdays and Sundays we do not have any elective bookings unnecessarily so it is not used to full hilt seven days a week.

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THE CHAIRMAN: Would it be more efficient to find staff and so make use of these facilities on Saturdays?

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REV. SISTER JANET: I would consider it would be more efficient. I don't know where you find them.

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THE CHAIRMAN: Is there something more than staff involved? What about the practice of the way the surgeon has organized his practice in life?

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REV. SISTER JANET: Well I think I would ask Dr. Welsh to comment on that. I think that they would be glad to operate if the place was ready for them.

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DR. WELSH: I think that is true. I think surgeons would be quite willing to work on Saturday morning. I think, however, if present conditions continue where we don't work on Saturday morning it might be that

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Welsh

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4 the subsequent generation of surgeons might feel they
5 should not work on Saturday mornings either.

6 THE CHAIRMAN: I suppose it is the
7 same thing, the non-availability of staff that enables
8 you to say if we could obtain sufficient personnel to
9 staff our radiology and laboratory departments, we
10 could expedite preoperative investigation.

11 REV. SISTER JANET: Mr. Chairman,
12 mostly in those departments and in the operating room
13 you just keep a skeleton staff on Saturdays and if you
14 wanted to take in electively anything in those departments
15 you would really have to have as complete a staff on
16 Saturday as you do any other day in the week.

17 THE CHAIRMAN: Where do you draw this
18 staff from? Where do you find them? If you had to go
19 out and look for them, where do you find them?

20 REV. SISTER JANET: I almost feel like
21 Eddie Cantor, out of the everywhere into the here kind
22 of idea.

23 Some of our nursing staff comes from
24 our own school. We have a large nursing school and
25 some of them too are new Canadians. Some have come from
26 England, some have come from Ireland, and so on.

27 In regard to the lab and x-ray again
28 we have training facilities. Most of them have come from
29 our own school. Some of our lab technicians are not
30 registered technicians. They are people who have come
to us trained in one particular phase of it and many
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Welsh

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3 training taxed to their capacity?

4 REV. SISTER JANET: Yes. We always
5 have as many students as we can take.

6 THE CHAIRMAN: Not only for nursing
7 but for these various other things?

8 REV. SISTER JANET: Yes.

9 THE CHAIRMAN: That is not sufficient,
10 in the long run, to supply your own needs?

11 REV. SISTER JANET: No, that is right.
12 In all those phases too many times they come from out
13 of town and want to go back to their own towns.

14 THE CHAIRMAN: From your experience
15 have you any suggestions to make by which this situation
16 that you recognize might be improved?

17 REV. SISTER JANET: I think we have
18 to look at this question of education very thoroughly.
19 For instance, in laboratory and in x-ray you can only
20 teach so many people in your own facilities. They get
21 to the point where you can't teach them any more. They
22 won't learn anything. It may be that we have to think
23 of some kind of a central school where we can draw from,
24 maybe use the clinical experience in other hospitals
25 where they might not have the staff to do this didactic
26 teaching.

27 THE CHAIRMAN: In the matter of
28 admissions, and perhaps more particularly with discharges
29 have you in Ontario any provision by which there is an
30 automatic review of patients after they have been in
hospital a given number of days?

REV. SISTER JANET: Yes. You mean



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Welsh

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through the Ontario Hospital Services Commission?

THE CHAIRMAN: Yes.

REV. SISTER JANET: A report has to be made by the physician in charge of a patient every 30 days.

THE CHAIRMAN: What do you find in relation to that period? Is there an increase in the rate of discharges immediately before that 30 day period?

REV. SISTER JANET: No, I don't think so. I think that basically at our place the beds are so much in demand that the doctor -- there is no abuse of them really. The doctor will discharge the patients as soon as they can be discharged.

THE CHAIRMAN: Your patient days stay of 13 days, you say in your view is quite satisfactory?

REV. SISTER JANET: Yes.

THE CHAIRMAN: It may be a little longer than some figures we have had as a national average. Have you any, apart from the explanation you gave about these various long stay people which I imagine must occur in other hospitals as well, have you any other reason? Is there any other reason?

REV. SISTER JANET: I think we nearly always take it for granted in a university teaching hospital the stay will be a bit longer than in the other hospitals.

THE CHAIRMAN: What about your stay in the maternity section?

REV. SISTER JANET: St. Michael's has its own peculiarities there. Our stay has always been

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Welsh

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THE CHAIRMAN: Now, has there been any change in that length of stay period in relation to the period before the hospitalization insurance program went in?

REV. SISTER JANET: I am sorry, I really didn't check that figure. I think it has always been around 12 to 13 days. In my own time I don't remember it being below 12.

THE CHAIRMAN: In connection with diagnostic procedures, it has been suggested to us that because diagnostic procedures, x-ray and so forth, are paid for under the Hospital and Diagnostic Services Act there may be an inclination on the part of physicians to bring patients into a hospital for these diagnostic services that might not otherwise require hospitalization because there is no charge at the time to the patient.

Have you any views to express on that?

REV. SISTER JANET: Well I think that is a logical consequence to come from that, the fact that we isolate out-patient care from the insurance act. Whether there is any real abuse of it, I am not sure.

In many cases some of those procedures are pretty difficult procedures and I am not sure whether a patient could take them as an out-patient. Maybe Dr. Brooks might like to comment on that.



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Brooks

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6 hospital their condition is such that any diagnostic
7 procedure would logically be part of their hospital care
8 and treatment. I don't think they are sending them
9 just for the convenience of diagnostic service because
they are paid for.

10 THE CHAIRMAN: I am not suggesting that.
11 I am not suggesting anything. It has been suggested
12 to us, because of this prepayment feature, that doctors
13 may be inclined to admit patients to the hospital to
14 save the patient money because they will not have to
15 pay out any cash immediately for the x-ray and diagnostic
procedure.

16 DR. BROOKS: Oh, I think there are
17 instances where the patient, if the doctor's intention
18 is to have certain x-rays and also to admit that patient,
19 I think that the patient really appreciates that these
20 x-rays are taken after the patient is in hospital rather
than before. Does that answer your question?

21 THE CHAIRMAN: Yes. Now that takes
22 us to the next stage as to the advisability of having
23 the out-patient service, including diagnostic service,
24 x-rays and so forth, brought under the provisions of
25 the Hospitalization and Diagnostic Services Act so as
to be covered and not requiring any minimum payment.

26 DR. BROOKS: Yes, that would shorten,
27 certainly hospital days stay.

28 THE CHAIRMAN: Are the hospitals, I
29 am speaking now generally, in Ontario prepared to assume
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5 I suppose, your own hospital.

6 REV. SISTER JANET: Mr. Chairman, if
7 we took it for granted that maybe fewer procedures would
8 be done in the hospital and more would be done on an
9 out-patient basis, probably the thing would average
10 itself out.

11 THE CHAIRMAN: Well now, perhaps you
12 may not be able to make that assumption because with
13 your waiting list if the bed is not occupied for
14 diagnostic purposes, it will be occupied by somebody
15 else who is clamoring for admission so that perhaps
16 you cannot make that assumption but take it on the basis
17 that your beds are going to be occupied anyway. I think
18 we have to face that.

19 REV. SISTER JANET: If we could not
20 make the assumption that there would be less diagnostic
21 work, less investigation work done in the hospital, our
22 present facilities I do not think could be taxed much
23 more. I think that, on the whole, our laboratory and
24 x-ray, the way it is going at present is doing about as
25 much as they can.

26 THE CHAIRMAN: Then if this added
27 responsibility was asked of you, you think you would
28 find it difficult to accept?

29 REV. SISTER JANET: Yes. We would
30 have to do something to enlarge those departments I am
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Brooks

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3 prepared to take all the work from the private labora-
4 tories would you not Sister?

5 REV. SISTER JANET: Yes.

6 COMMISSIONER McCUTCHEON: And the
7 clinics?

8 REV. SISTER JANET: Yes.

9 COMMISSIONER McCUTCHEON: At the moment
10 you could not do that?

11 REV. SISTER JANET: No.

12 THE CHAIRMAN: How long a time would
13 you think hospitals require to equip themselves to do
14 that?

15 REV. SISTER JANET: That all depends
16 on so many factors. Like, for instance, at St. Michael's
17 we would not have any more space to put anything more.
18 Other hospitals that have space, could find the
19 financing, then they could probably take about 15 months.

20 THE CHAIRMAN: The financing, we
21 will assume, will be by the Commission. You talk about
22 the capital financing?

23 REV. SISTER JANET: Yes. That is
24 right. Probably take you about 15 months, couple of
25 years.

26 THE CHAIRMAN: Not something that can
27 be done overnight?

28 REV. SISTER JANET: No.

29 THE CHAIRMAN: It is done in Manitoba
30 and they appear to have been able to live with it. I
am wondering why if it is possible in one Province, in
a Province of Manitoba where the population is rather

prepared to take all the work from the private labor-
 tories would you not expect?

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REV. SISTER JANET: Could be too, Mr. Chairman, that hospitals in the City wouldn't be in the same position as we are. Like the load would be spread out more. On an out-patient basis not necessarily the people on the periphery would come downtown for those services.



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RAY, STANLEY JAMES: Could be too, Mr.

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out more. On an out-patient basis not necessarily the
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Brooks

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COMMISSIONER McCUTCHEON: Dr. Brooks, you appeared to me at one stage, you just touched on this, and I would like to pursue it a little further.

You are taking the position, as I understand it, that in your experience people were not admitted to hospital purely for diagnostic treatment?

DR. BROOKS: That is right.

COMMISSIONER McCUTCHEON: Is there a tendency towards this sort of thing? I am admitted to hospital perfectly genuinely, and there is no question that I am entitled to admission; is there a tendency to say: "Now, while you are here we will just look at this, that and the other thing."?

DR. BROOKS: There is a tendency to that, sir.

COMMISSIONER McCUTCHEON: That is a tendency that I might have resisted five years ago, but that I wouldn't resist today, speaking as a patient?

DR. BROOKS: Yes, it is.

COMMISSIONER VAN WART: If the patient is admitted for diagnostic purposes only, does the Commission pay that hospitalization or not?

DR. BROOKS: No, the Commission does not pay it.

COMMISSIONER VAN WART: Well, that is a check on it, isn't it?

DR. BROOKS: That is right.

THE CHAIRMAN: What is the incidence of that? I mean, are there such cases?

DR. BROOKS: I don't think, at the



You appeared to me at one stage, you just touched on this, and I would like to pursue it a little further.

You are taking the position, as I understand it, that in your experience people were not admitted to hospital merely for diagnostic treatment?

DR. BROOKS: That is right.

COMMISSIONER McCUTCHEN: Is there a

tendency towards this sort of thing? I am admitted

to hospital perfectly genuinely, and there is no

question that I am entitled to admission; is there a tendency to say: "Now, while you are here we will just

look at this, that and the other thing."?

DR. BROOKS: There is a tendency to

COMMISSIONER McCUTCHEN: That is a

tendency that I might have resorted five years ago, but

that I wouldn't resist today, speaking as a patient?

DR. BROOKS: Yes, it is.

COMMISSIONER VAN WART: If the patient

is admitted for diagnostic purposes only, does the

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DR. BROOKS: I don't think, at the



Brooks 12419

present time, no.

THE CHAIRMAN: Well, that is what I am told, that everybody is admitted for some other reason, even if it is going to be for diagnosis. I don't think we ever heard of it in our hospital, did we, Doctor?

COMMISSIONER BALTZAN: We have.

THE CHAIRMAN: Well, I was in there once.

COMMISSIONER McCUTCHEON: Special rules for the Chairman of the Board.

COMMISSIONER BALTZAN: Reverend Sister and gentlemen: I am so intimately acquainted with your problems I hardly have anything to ask you, certainly nothing in a general way. There are one or two things specifically insofar as your hospital is concerned.

No. 1, have you any idea about the comparative numbers of people on the waiting list currently, or since the Hospital Insurance Act, as compared to previous years? Has that long waiting list become longer?

REV. SISTER JANET: Yes, Doctor. In fact, I think this year it is much longer than it was last year.

COMMISSIONER BALTZAN: Would that be because either of increased population, or because of greater accessibility for people to enter hospital? What would you say?

REV. SISTER JANET: Well, I think personally a great deal is due to the fact of the



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Brooks

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because either of increased population, or because of greater accessibility for people to enter hospital? What would you say?

REV. SISTER JAMES: Well, I think

personally a great deal is due to the fact of the



Sister Janet 12420

increased population.

DR. BROOKS: I might add to that, and one third point, the increase of the medical staff. Therefore, each time you add a new specialist and consultant to your consulting staff, there is a new demand at the admitting office for his patients. It is proportionate to the increase in medical and surgical staff of your hospital.

COMMISSIONER BALTZAN: You were speaking a minute ago about admitting patients, and the question of admitting them in relation to diagnosis, and always, as we have heard it up till now, and even now, that that element revolves about x-ray and laboratory, but that is not always the reason for the admission re-determination of the diagnosis. There are other reasons. Do you find that it is frequently necessary to admit a patient for observation in order to know, even though you don't make any tests?

DR. BROOKS: That is right.

COMMISSIONER BALTZAN: And that is perfectly legitimate?

DR. BROOKS: Yes.

COMMISSIONER BALTZAN: And regarding the other question, about a patient who has been in the hospital and while he is there, before discharge, other things are being done now. How would you regard that, as just a luxury thing, or is that still a service given for the individual?

DR. BROOKS: I think that is now well under the control of the doctor. Any procedure that is



Sister Janet

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DR. BROOKS: I think that is now well

under the control of the doctor. Any procedure that is



Brooks 12421

carried out while he is in hospital is an adjunct to the reason for him being in hospital. The patient is admitted for a primary diagnosis, and is being taken on to surgery, and many x-rays would be taken to see if he has other things.

COMMISSIONER BALTZAN: And lastly, Sister, you always have to put in, seemingly, quite a few extra beds. Do you work under the premise of the rule that occupancy must not be over the rate of 80% of your bed capacity?

REV. SISTER JANET: No, we do not work on that principle. We work on the principle that we are there to serve the people of Toronto, and if they need to be taken care of, we take care of them to the best of our ability.

COMMISSIONER BALTZAN: Of course, you know what I am referring to. That you cannot obey that sort of general rule in a practical sense. It is impossible, so that when you are speaking of overcrowding, extra beds, it is not that you are working in that range of 20% vacancy. You are working over and above that?

REV. SISTER JANET: Yes, when every bed is full then we still have to put up extra beds.

COMMISSIONER BALTZAN: How well I am acquainted with that. Thank you.

COMMISSIONER GIRARD: Would you be paid for the extra beds?

REV. SISTER JANET: Yes. Well, basically no, I guess, because the way we are paid now is we budget,



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Sister Janet 12422

we submit an annual budget. Say our operating costs are going to be 4,500,000 dollars, and they approve that much, well then, we get paid 1/24th of that amount twice a month through the year, and we no longer get paid according to patient billing.

COMMISSIONER GIRARD: You get paid for the number of beds for which you are registered with the Hospital Commission, and if you have beds over that, you are not paid for those beds?

REV. SISTER JANET: No, not exactly for the beds, but you are paid for your operating costs, and if, at the end of the year, they are more than we budgeted for, the Rate Board looks at it and, if you have good reasons for it, they will accept that.

THE CHAIRMAN: You find the operation with the Commission quite satisfactory, do you?

REV. SISTER JANET: Most of the time, yes.

COMMISSIONER GIRARD: Coming back to a question that we spoke about earlier. Outside of the cardiac surgery and orthopaedic surgery that I know takes a very long time for the patient to stay in the hospital, you say that many patients require at least three weeks stay after many forms of general surgery. Isn't three weeks a little longer than usual for general surgery? At least three weeks you say.

REV. SISTER JANET: Well, in some cases it would be long, but it would depend on what procedures were done.

COMMISSIONER GIRARD: I did take out



Sister Janet 11432

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Welsh

12423

neuro-surgery and cardiac surgery and the specialties that do take very long, but for general surgery?

DR. WELSH: Well, in a community hospital I suppose that they take in everything, like hernias and various things like that, which are relatively short-stay patients. The more specialized the hospital becomes, you become specialized in general surgery just as you become specialized in any other form of surgery, and surgery, in the larger and more well-established hospitals, probably the percentage of cancer patients are longer, patients who have complications developed in other hospitals, and are transferred to the hospital, which is a problem which requires much longer patient care than, for example, the more common thing like appendicitis.

I remember in my days as a houseman, that a large percentage of our patients appeared, acute appendicitis and hernias, and that sort of thing, and now, in our hospital, we have real difficulty in getting a sufficient number of that sort of thing to give what we think would be good teaching to our house staff, so I think that is one of the reasons that this is.

COMMISSIONER BALTZAN: You are an affiliated teaching hospital, I understand?

DR. WELSH: Yes, sir.

COMMISSIONER BALTZAN: Are you classed amongst the closed or amongst the open hospitals?

DR. WELSH: We are not a closed hospital. We are closed insofar as the teaching block of beds, which are used for teaching, is concerned, but not

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Welsh

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otherwise.

THE CHAIRMAN: In that connection, we have had some discussion on this problem at various stages. Have you found, since the hospitalization program took over, that there is any change in the availability of clinical material for teaching merely from the fact that the hospitalization is prepaid and that all patients now come to the hospital as paying patients, and not public patients?

REV. SISTER JANET: No, on the whole we have had no problem there. That is a physical area and all those who have beds in that particular area are used for teaching, and I don't think that the doctors have run into many individual cases.

THE CHAIRMAN: You see fear- apprehension, perhaps, is a better way to put it, has been expressed to us here this week and in other places that this prepayment principle, both in hospitalization and it was suggested it would be carried forward also in the prepayment of medical services, would have a serious effect on the availability of clinical material for teaching. Would Dr. Welsh have any views to express on that from your experience in the last three-and-a-half years?

DR. WELSH: Actually, in our hospital, I don't think that we have. That block of beds that are set aside are teaching beds and it is true that sometimes people who wish private accommodation are unable to get it and go into that area, and when that occurs, of course, they are used as teaching.

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Welsh 12425

Now, I can see where it might be that the pressure might get so great that people would say if they paid for what they consider better accommodation, private ---

THE CHAIRMAN: Well, they are only prepaid for ward accommodation.

DR. WELSH: Yes, sir, but for a little extra they can insure themselves for some other accommodation.

THE CHAIRMAN: That is privately. I mean, they cannot say that that is the obligation of the Hospital Commission, to give them more than the Hospital Commission has contracted to give.

DR. WELSH: That is true, but I would just say this, though, that if the feeling became strong and there were private beds available for those people, why then, I think there would be a depletion in our number of people available for teaching.

THE CHAIRMAN: Then, a refinement of this apprehension in terms of the maternity ward. Have you had any experience there with a great desire for privacy and not to be used as clinical teaching material on the part of the mother?

REV. SISTER JANET: I don't think we have experienced anything there either, Mr. Chairman. We have an out-patient clinic, as you know, and we have a pre-natal clinic and so forth, and I don't think they have been worried about the amount of teaching material.

THE CHAIRMAN: Even on the in-patient?

REV. SISTER JANET: Yes, they come in



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THE CHAIRMAN: Then, a relinquishment of

this approximation in terms of the maternity ward.

Have you had any experience there with a great desire

for privacy and not to be used as clinical teaching

material on the part of the mother?

MRS. ELLIOTT JAMES: I don't think we

have experienced anything there of that, Mr. Chairman.

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a prenatal clinic and so forth, and I don't think they

have been worried about the amount of teaching material.

THE CHAIRMAN: Even on the in-patient?

MRS. ELLIOTT JAMES: Yes, they come in



Sister Janet 12426

as an in-patient.

COMMISSIONER McCUTCHEON: How many
beds are in your teaching unit?

REV. SISTER JANET: Approximately 50%
of the beds are for teaching.

COMMISSIONER McCUTCHEON: If everybody
objected to being used as teaching material, your
waiting list would be quite long?

REV. SISTER JANET: That is right. If
you come in as an emergency some night you might be
teaching material.

DR. BROOKS: We just finished the
Council exams, the oral exams, which require assignment
of a patient to the student, and we had 28 candidates
a day for four days, and in that experience only one
patient objected, and that was because she was being used
for the second time in four days.

THE CHAIRMAN: Well, we are very grate-
ful to you for this information on this experience,
because it has been put forward very seriously in some
quarters.

REV. SISTER JANET: We were worried, too,
when the plan was coming in, that was one of the things
we kept talking about, but to date, we have not suffered.



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4 COMMISSIONER BALTZAN: How are these
5 patients channeled to the teaching wards? Are there
6 certain types which naturally fall into that category
or are they selected? What is the method?

7 DR. BROOKS: One of those would be,
8 (a) our out-patient clinic, the second would be those
9 patients who are only covered by standard ward
10 insurance, they automatically go to the teaching unit.

11 THE CHAIRMAN: Nobody is covered by
12 the Commission for any more than the standard?

13 DR. BROOKS: That is right, but some
14 pay extra through other means. But all insurance patients
15 under the hospital scheme go into our teaching units,
16 and they come from our out-patient clinic, and those
17 who are admitted through the office under the Hospital
Commission.

18 COMMISSIONER BALTZAN: And those who
19 have prepaid medical plans?

20 DR. BROOKS: Those who have the prepaid
21 medical plans will ask for semi-private and private. If
22 they ask for it they will be so admitted, and if it is
not available they will go into our teaching unit.

23 COMMISSIONER BALTZAN: If what is not
24 available?

25 DR. BROOKS: The semi-private or private.

26 THE CHAIRMAN: Do you find they are
willing to go?

27 DR. BROOKS: Yes. We do make an effort
28 to transfer that patient when a bed becomes available,
29 but it isn't easy to do, because if she does that then
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Brooks

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4 she just takes it out of one pocket and into the other;
5 it makes it difficult for the patient who is supposed
6 to be there and has to send this one into the ward where
7 she took the patient from. But occasionally they are
8 transferred when a bed is available. We don't have too
9 much trouble.

10 THE CHAIRMAN: Well, Sister Janet,
11 gentlemen, we are very grateful to you, as I mentioned
12 at the beginning, for having accepted the invitation to
13 give us this review. We must necessarily try to get
14 the best information possible in terms of the operation
15 of the Hospitalization and Diagnostic Services Act and
16 utilization, because costs are between \$670 million and
17 \$700 million a year, and that is a very important subject,
18 and we look to hospitals such as yours for information
19 and help in this regard. Thank you very much.
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gentlemen, we are very grateful to you, as I mentioned at the beginning, for having accepted the invitation to give us this review. We must necessarily try to get the best information possible in terms of the operation of the Hospitalization and Diagnostic Services Act and utilization, because costs are between \$870 million and \$700 million a year, and that is a very important subject and we look to hospitals such as yours for information and help in this regard. Thank you very much.



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4 THE SECRETARY: Mr. Chairman, the next
5 submission is from Sarnia General Hospital, which is
6 a verbal statement, and Mr. Hewig will make his presenta-
7 tion.

8 SUBMISSION OF
9 SARNIA GENERAL HOSPITAL

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11 APPEARANCES: Mr. A.H. Hewig

12 MR. HEWIG: Mr. Chairman, Commission
13 Members, there isn't a great deal I can add to what
14 Sister Janet has said.

15 THE CHAIRMAN: I was just going to say,
16 very fortunately in this sense, and it applies to Dr.
17 Sharpe and Mr. Wallace, this discussion we have had has
18 alerted you to the subjects which we are interested in in
19 terms of hospital operation. So if you wish to make a
20 general statement we would be very pleased to have it,
21 dealing with those topics and having regard to the
22 questions posed in my letter.

23 MR. HEWIG: Well, Mr. Chairman, I
24 was going to ask for that privilege, because I am sure
25 you and the Commissioners are aware that I am from a
26 smaller community and I imagine that that was purposely
27 done.

28 THE CHAIRMAN: Very intentional, so
29 that we get a sort of an across the board picture.

30 MR. HEWIG: We have some of the same
problems; we don't have them as severe as some of the ---



THE SECRETARY: Mr. Chairman, the next

submission is from Santa General Hospital, which is a verbal statement, and Mr. Hewitt will make his presenta-

SUBMISSION OF
SANTA GENERAL HOSPITAL

APPEARANCES: Mr. A.H. Hewitt

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Hewig

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THE CHAIRMAN: How big is your hospital?

MR. HEWIG: Our hospital at the present time is 250 beds, and the community from which we draw patients is about 80,000 population.

Now, I have broken down your letter into different subjects as you have listed them, Mr. Chairman.

The first one, the relative need for active convalescent and chronic beds and rehabilitation facilities. In our area -- and I was amazed to hear Sister Janet mention about the same figure -- the need for chronic beds is about 9% of the active treatment beds in our area.

As it happens, when we finish a small expansion program in a year or so the number of chronic beds authorized in our particular area will be just about 9% of the total active treatment beds in the area, and I would gather that the Ontario Hospital Services Commission has some sort of formula which brings this about.

Just briefly on our rehabilitation facilities. We feel in our small community that we can't have a comprehensive type of rehabilitation facility because of population, but we also feel that with more rehabilitation facilities than we do have in occupational therapy and physiotherapy and perhaps in speech therapy, that in some instances more patients would benefit as out-patients, and in some instances it might tend to reduce the length of stay of certain kinds of patients in the hospital.



Hewig

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4 The length of stay then follows, and
5 our experience has been perhaps not unusual, I think
6 rather it is usual, since 1958, that the length of stay
7 has increased. In 1958 our average length of stay in
8 the hospital was 8.7 days; in 1959 it was 9.4 days;
9 in 1960, 9.9 days and in 1961, 9.9 days. It seems to
10 have sort of stabilized itself just around 10 days in
11 the last two years.

12 THE CHAIRMAN: Have you any observation
13 to make in regard to that?

14 MR. HEWIG: Well, the observation --
15 I presume you are wondering about the 13 days in Toronto?

16 THE CHAIRMAN: No, the increase, since
17 1958, since coming into effect of the hospital scheme,
18 since it became applicable in Ontario on the first of
19 January, 1959.

20 MR. HEWIG: I think my observation
21 would involve two things, Mr. Chairman. One is that a
22 good many of the -- some proportion of the population
23 in our area has never had hospitalization insurance
24 before, for a number of reasons: One, they were unable
25 to get it because of some pre-existing condition or
26 their hospitalization would be limited because of that;
27 second, the types of patients coming into our hospital
28 have gradually changed, the types have changed in that
29 we get an older and older group of patients in along
30 with the younger people, the younger age groups, and a
good many of those patients are longer-stay patients and
some of them have not been in hospital before.

THE CHAIRMAN: Do you see any indication



Hewig

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4 that people stay in hospital because -- perhaps you may
5 not be able to put your finger on it, but to tie it
6 to the fact that the hospitalization is prepaid, there
7 is no immediate outlay necessary by staying an extra
8 day or two?

9 MR. HEWIG: I would have to say, Mr.
10 Chairman, that there is some indication in our community,
11 and I speak only for our hospital -- we have two hospitals
12 in the city -- I have to say that there is a slight
13 indication that some of the people stay an extra day,
14 and I would comment on that in this way, that although
15 we have an active medical staff committee investigating
16 these types or looking into the stays of many patients,
17 our waiting list is not nearly so long as that in
18 Toronto, and I don't mean to say at all that this is
19 an abuse. I would have to answer honestly, though, that
20 there are some patients who stay an extra day.

21 COMMISSIONER STRACHAN: Since the
22 hospital scheme has come in have re-admission increased?

23 MR. HEWIG: I am not aware of that,
24 that re-admissions have increased. They may have, but
25 I am not aware of that.

26 COMMISSIONER STRACHAN: Especially
27 some of your early discharges?

28 MR. HEWIG: Well, I am not aware of
29 it.

30 THE CHAIRMAN: It hasn't been enough
to impress itself on you?

MR. HEWIG: No.

COMMISSIONER STRACHAN: There is the



Hewig

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4 internal management, shorter hours of work, and so on
5 since the plan came in. These two things have gone
6 on independently but at the same time?

7 MR. HEWIG: I don't know that they
8 are connected, but they are parallel.

9 COMMISSIONER STRACHAN: And it tends
10 to increase the stay; the patient comes in on Sunday and
11 can't have any work done till Monday.

12 MR. HEWIG: I am not aware of that in
13 our case either, because one of our biggest days is
14 on Saturday, on surgery, and our pathology and x-ray
15 departments are open seven days a week. I don't think
16 it a factor that shorter work week meant a longer stay
17 in our instance; I am not aware of that.

18 COMMISSIONER STRACHAN: They will x-ray
19 and start gastrics on Friday or will they have to wait?

20 MR. HEWIG: They start gastrics on
21 Friday, yes, sir.

22 COMMISSIONER McCUTCHEON: What is your
23 waiting list?

24 MR. HEWIG: Right now it would total
25 about 20 patients or 20 potential patients. It runs
26 higher at other parts of the year. I was amazed as to
27 the number at Toronto, at St. Michael's, and I am sure
28 they have them at the other hospitals in Toronto. But
29 we have had waiting lists, minor waiting lists now for
30 six or seven years, and we operate at a occupancy of 96%,
which is not to our liking, but with such a high occupancy
our waiting list is lower than it could be.

COMMISSIONER McCUTCHEON: How many beds

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COMMISSIONER McCUTCHEN: What is your

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COMMISSIONER McCUTCHEN: How many beds?



Hewig

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are there in the other hospital in Sarnia?

MR. HEWIG: In the Sister's Hospital,
328.

THE CHAIRMAN: Well, this matter of
the 20, can you translate that to days?

MR. HEWIG: Oh, at the present time
that 20 would take about a week to admit. As Sister
Janet said, we find the same situation, that our admissions
for in-patients coming through our emergency department
seem to be climbing, and there are many days when we
take only patients who have been admitted through the
emergency department; we are unable to take the elective
cases we have booked for that day.

COMMISSIONER BALTZAN: There are also
patients who develop an emergency and are sent to the
hospital, as, say, pre-coronary condition, not necessarily
going through but they are sent there as emergency
cases, let's say, cases that have been booked for a week
or two or a month hence may in the interim suddenly
become acute. Do you have an out-patient department
where patients go to the hospital and receive total care,
by that I mean not only x-rays, laboratory, but also
physical examinations, et cetera, in your out-patient
department?



Hewig

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MR. HEWIG: No, we don't, sir. In our hospital we don't have an organized out-patient department. Our emergency department functions to a very minor extent in that way, but no physical examinations.

COMMISSIONER BALTZAN: In other words, you differ extensively from the kind of out-patient services in the metropolitan areas or large hospitals?

MR. HEWIG: Yes, we do.

COMMISSIONER McCUTCHEON: You are not a teaching hospital?

MR. HEWIG: I beg your pardon?

COMMISSIONER McCUTCHEON: You are not a teaching hospital?

MR. HEWIG: We are not a teaching hospital.

COMMISSIONER BALTZAN: You say you are not a teaching hospital. I assume a 250-bed hospital, or should I assume, you are accredited in internship?

MR. HEWIG: We are accredited for junior intern training, yes, sir. We are not affiliated with any university or any medical school and because of that we are not, I think, because of that we are not called a teaching hospital.

COMMISSIONER BALTZAN: Are any of your departments accredited by the Royal College of Physicians for advanced training for post-graduate work? The reason I am asking that is we are thinking in terms of, the question has been put to us, how can we improve the capacity for increased post-graduate training in

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Hewig

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4 hospitals? Are any of your departments accredited
5 by the Royal College, say, the x-ray department, so
6 you could not only have junior interns through rotation
7 but men serving a year that may be counted towards
8 their specialty?

9 MR. HEWIG: Our only department is
10 the pathology department, one year post-graduate
11 training.

12 COMMISSIONER BALTZAN: That is the
13 answer I was looking for. That is the only one so far?

14 MR. HEWIG: That is the only one so
15 far, yes, sir.

16 THE CHAIRMAN: Do you operate on any
17 ratio of occupancy per day? Do you retain any number
18 of beds out of service?

19 MR. HEWIG: We don't, Mr. Chairman,
20 except for the fact that we always keep about three
21 beds available for emergency cases that might come in
22 during the night. Unlike Sister Janet's hospital, we
23 do have beds sitting out in the hallway which we use
24 365 days in the year. We always have room for another
25 one or two or three in case the three vacant beds we
26 saved are not sufficient.

27 COMMISSIONER BALTZAN: Is that an old
28 custom or a new development, having that number of extra
29 beds?

30 MR. HEWIG: The setting up of beds in
the corridor - it has been a custom of seven years
standing, which is the length of time I have been there.
It has been since that time we felt we have been



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standing, which is the length of time I have been there.
It has been since that time we felt we have been



Hewig

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overcrowded. With our slight expansion program we expect we will eliminate the beds in the hallway.

COMMISSIONER VAN WART: What will that expansion be?

MR. HEWIG: The number of beds, 70 beds.

COMMISSIONER VAN WART: That will bring you up to what?

MR. HEWIG: 320 beds.

THE CHAIRMAN: Thank you, Mr. Hewig. We are obliged to you for having come from Sarnia to discuss this matter with us, because, as I say, we are anxious to have the experience of a metropolitan hospital and also of the larger of the smaller hospitals. We are very pleased you were able to come.

MR. HEWIG: Thank you, Mr. Chairman. It has been a privilege.



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THE CHAIRMAN: Dr. Sharpe?

SUBMISSION OF THE TORONTO GENERAL HOSPITAL

Appearance: Dr. J.E. Sharpe

DR. SHARPE: I would first like to thank you for the invitation to appear before you as an individual and without the necessity of preparing a brief. I have, however, prepared some information in reply to the questions to which you made reference in your letter of invitation. I can read it or answer questions as you wish.

THE CHAIRMAN: We will leave it to you, Dr. Sharpe. Perhaps, having prepared it, you might prefer to read it.

DR. SHARPE: Certain information concerning the Toronto General Hospital perhaps would be of interest to you. It is a voluntary public general hospital and has been serving the people of Toronto since 1820. It was first established as the York General Hospital, the need for a hospital becoming apparent, we are told, following the war of 1812. Its financing was a community effort with the funds principally being donated by a group known as The Loyal and Patriotic Society, and from money obtained from the melting down of medals which were to be awarded for service in the war of 1812 but for some reason were not presented.

In 1847, the Toronto General Hospital was incorporated by an Act of the Legislature, a Special Act of what was then the Province of Canada. It moved



Sharpe

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from its original location at the corner of King and John Streets to Gerrard Street, east of Parliament, in 1855, and to its present site in 1913.

Students in Medicine have received training in the Toronto General since the early 1830's. At that time there was not a School of Medicine; students were taught as apprentices to various doctors and without the benefit of an organized course. It was not until the early 1840's that Medical Colleges were established, the University of King's College in 1844, Trinity College Medical School in 1850. I believe it was in 1903 that there was an amalgamation of the Medical Schools then in existence with the formation of the University of Toronto Medical School.

The Toronto General has conducted a School of Nursing since 1881 and has now graduated 4,596 nurses.

The Hospital has had a Social Service Department since 1911 when, under the auspices of the Hospital Visitors, a group of volunteer women, and the Medical Staff, Medical Social Work came into being.

In 1952 the Hospital had a very successful public campaign for funds, raising approximately sixteen million dollars, about two million beyond the objective which was set at that time. Since then, the Hospital has been engaged in a program of new construction and the modernization of existing buildings and has spent more than eighteen million dollars over the past seven years and still has not fulfilled the needs as they are envisaged.

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Sharpe

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The Toronto General Hospital has approximately 1350 beds, plus 200 bassinets. Of these, 55% are public or standard ward beds. In 1961 the Hospital admitted 30,298 patients and gave approximately 404,000 days' care. There were 3,859 babies born in the Hospital. In addition to the In-Patient care provided there were some 90,000 Out-Patient visits and 35,000 persons were seen in the Emergency Department.

The Hospital is governed by a Board of Trustees, numbering 27. Five of the members of the Board are appointed by the Governors of the University of Toronto and two of the members are appointed from the Medical Staff.

The Hospital Budget for this year is just under fourteen-and-a-half million dollars. The Hospital has 3,000 employees, including part-time and relief staff, student nurses, internes and residents but not including Medical Staff. All the Active Medical Staff have teaching appointments with the University of Toronto and they do not receive payment for the service given to patients either on the Public Wards, or in the Out-Patient Department.

As mentioned previously, admissions in 1961 numbered 30,298. In 1960 - 28,924 patients were admitted; in 1959 - 27,303. The number of days' care given increased from 350,000 in 1959 to 377,000 in 1960, to 404,000 in 1961.

THE CHAIRMAN: Dr. Sharpe, have you any comment to make on this rise in that three-year period?



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THE CHAIRMAN: Mr. Sheppard, have you

any comment to make on this rise in that three-year

period?



Sharpe

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DR. SHARPE: Sir, it is associated with our building program. I go on to say:

These figures are probably not too meaningful because the Hospital has been opening new services as they became available, the result of the construction and modernization program, and as we are able to obtain the necessary staff.

The length of stay during the last decade has not changed materially. Patients referred to the Hospital usually require considerable investigation and consultation with the use of special services, facilities and equipment. Of the number of patients admitted to the hospital, 25% came from outside of this city and the County of York.

The average stay during the decade has varied from a low of 13.9 to a high of 14.8. In 1961 it was 14.7; 1960 - 14.6; 1959 - 14.5. During the last few years a slight rise has occurred but to evaluate what this means is difficult because we have added special services which require rather longer periods of hospitalization such as Units for Clinical Investigation, Cardiovascular Surgery, Neurosurgery, Respiratory Paralysis, Coronary Thrombosis, the hospitalization of paraplegic patients, an Artificial Kidney, a Department of Rehabilitation and Physcial Medicine, amongst others. Perhaps again the length of stay is in part controlled by our needs for beds and the number of patients awaiting admission. The waiting list usually numbers slightly in excess of 1100. Of this number about 950 are elective admissions, 150 urgencies.



Sharpe

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We attempt to admit our emergencies the day the request is received. Appropos of some discussion that has gone on, the first four months of this year we admitted, on an average, through our Emergency Department, 17.2 patients per day. The occupancy of the Hospital for the twelve months' period during 1961, taken as of 12 o'clock midnight on each day, including all services with the exception of obstetrics, was 95%.

Of the total number of patients in Hospital we believe that at any time we have approximately 150 to 160 patients that could be moved elsewhere should accommodation be available such as convalescent, active prolonged treatment and chronic beds or some type of accommodation such as a Nursing Home or a Home for Elderly People.

At the present time we have 61 beds not in use. Thirty-two of these were provided in our planning for future needs. It is intended to use them for a service other than that for which they were originally planned.

As a Teaching Hospital affiliated with the University of Toronto, we have on any one day approximately 350 Medical Students in the Hospital; 250 of these will be on the Wards, attending Clinics, and so forth; 100 in lecture theatres. We have 130 young Doctors receiving post-graduate training as Internes, Assistant Residents and Residents.

We are associated with the University in its graduate training for specialists and others.

The School of Nursing number~~s~~ 264. We

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We are associated with the University in its graduate training for specialists and others. The School of Nursing employs 250. We



Sharpe

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have a two years plus one year course. The third year is what is spoken of as a Nursing Internship. There are also approximately 70 Student Nurses from other schools on affiliation in the Hospital at any time and 40 Nursing Assistants from the Provincial Course for Certified Nursing Assistants.

In addition to the education of these groups, we also undertake or assist in the training of Dental Students, Postgraduate Students in Social Work, Postgraduate Students in Hospital Administration, Laboratory Technicians, Radiological Technicians, Dietitians, Food Supervisors, Physical and Occupational Therapists, Speech Therapists, Operating Room Technicians, Hospital Clergy.

Thank you, Mr. Chairman.



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THE CHAIRMAN: You have this 150, 160, do you see any immediate relief for that? Anything in sight?

DR. SHARPE: I think that Sister mentioned the Riverdale Hospital which takes care of some of the chronic patients. We have to consider all convalescent patients which we feel might better be closer to the site of the hospital.

We have also what we call active prolonged treatment patients. They are patients over the acute stage but still needing --- an orthopaedic patient, rheumatic patient, cardiological patient that needs treatment beyond the acute phase. We think this could go into less highly cost beds.

THE CHAIRMAN: You are thinking about St. John's Convalescent?

DR. SHARPE: Yes.

THE CHAIRMAN: I understand that is used by the Toronto General?

DR. SHARPE: Yes. We use it a great deal.

THE CHAIRMAN: Even with that you still think this other ----

DR. SHARPE: There is the matter of distance.

THE CHAIRMAN: That is what? About six, seven miles?

DR. SHARPE: I guess it is further than that. Must be ten or twelve, I would think. The question of relatives going to visit. The people away from



Sharpe

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their own community and then again, the access to the physicians in the hospital.

THE CHAIRMAN: Do you find any treatment -- some of the questions we put forward this afternoon, do you find any inclination on the part of the profession to use the hospital for diagnostic purposes that might well be done either in the clinics or in an out-patient department?

DR. SHARPE: Well, sir, I don't think that we see -- I can't say that we don't, but I don't think that we see patients admitted for diagnostic purposes. We have the Utilization Committee, the Admitting and Discharge Committee. We are very active in following up length of stay. We are very active in following up the reason for admissions and with the waiting list we have everybody is anxious to see that the patient is discharged.

THE CHAIRMAN: Can you translate that waiting list into days?

DR. SHARPE: I would say with the elective list that we could run as long as six weeks, maybe longer than that sometimes. That is certain services. Not all. I am taking the average there.

COMMISSIONER BALTZAN: Thank you very much for the discussion. There is very little left to say after you have said what you have said. Speaking of the chronic illness accommodation that you have here, what stand does your hospital take in relation to your chronic illness wards or units; your arrangement has to be less costly and yet give the service?



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DR. SHARPE: I think that we are favourable to that type of arrangement. As I said, we break it into convalescent, active prolonged treatment, chronic, whatever you will, rehabilitation beds, if you wish, Doctor, and we are interested in this and we feel that there should be facilities for this type of patient.

COMMISSIONER BALTZAN: I am thinking chiefly of the long stay cases, not the permanently disabled, domiciliary cases.

DR. SHARPE: I don't know whether in a hospital such as ours we should think of the very long stay. I think we should probably be more intent on what we call prolonged active treatment type of patient.

COMMISSIONER BALTZAN: You spoke of 133 patients a day or something emergency?

DR. SHARPE: No. I said 17.3 patients came in through our emergency department the first four months of this year each day.

COMMISSIONER BALTZAN: Do you find that you can accommodate your emergency? When the call is there, are you stuck for a bed?

DR. SHARPE: We are stuck for beds frequently, yes, and we will put patients in examining rooms. We have what we call recovery beds associated with our emergency department and we will keep patients in there overnight waiting for beds the next day. Also private patients are put in public accommodation, as you commented on earlier. We do this. We do not like to keep beds in the corridors. In fact, we do not set them up in the corridors.

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hospital such as ours we should think of the very long
stay. I think we should probably be more intent on what
we call prolonged active treatment type of patient.

COMMISSIONER BARTMAN: You spoke of

100 patients a day or something emergency?

Dr. Schwartz: No, I said 100 patients
came in through our emergency department the first four
months of this year each day.

COMMISSIONER BARTMAN: Do you find
that you can accommodate your emergency? When the call
is there, are you stuck for a bed?

Frequently, yes, and we will put patients in examining
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keep beds in the corridors. In fact, we do not even take
up in the corridors.



Sharpe

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COMMISSIONER BALTZAN: I am curious about one other thing I don't know too much about. You mentioned a terrific figure of \$14,500,000.00. Is that your operating cost?

DR. SHARPE: That is our operating expense.

COMMISSIONER BALTZAN: That includes also the cost of this post-graduate teaching and teaching for ancillary services. Is that included in that total?

DR. SHARPE: That is in there, sir, that is right. We include the teaching within that \$14,500,000.00.

COMMISSIONER BALTZAN: My curiosity leads me one step further. Where do you get it?

DR. SHARPE: We do not get it all from the Commission. As you know, they pay us on a formula. They do not pay us on a cost basis. As far as the out-patient services, for example, we will lose about a quarter of a million dollars a year on out-patient clinic and out-patient services.

Out-patient services are X-ray, physical therapy, laboratory examinations that are given to out-patients and you will note under Section 73 J of the Act, which is a headache to us, and you must know about it, we have to include our gross revenue for out-patient services whether we collect it or not as a deductible against operating expense.

THE CHAIRMAN: Dr. Sharpe, in the operation of your teaching wards, have you found any reluctance on the part of the patients to be used as



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about one other thing I don't know too much about. You mentioned a certain figure of \$10,000,000.00. Is that your operating cost?

MR. SHAW: That is our operating

expense.

COMMISSIONER BALTIMORE: That includes

also the cost of this post-graduate teaching and teaching for auxiliary services. Is that included in that total?

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operation of your teaching wards, have you found any

reluctance on the part of the patients to be used as



Sharpe

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clinical material since the hospitalization program came into force?

DR. SHARPE: No, sir. We have not had that. We explain to the patients the purpose of it. I think what we are attempting to do is build up the physical attractiveness of our service and also provide them with consultation and medical care that very few would be able to purchase.

THE CHAIRMAN: The reason we put the question is because some of the medical faculty have, and particularly the medical faculty in Toronto, appear to regard this as something that might be serious in the future.

DR. SHARPE: I think, sir, we should not overlook it. We have not yet experienced this. It is true that we do have private patients admitted, or people that would like to have private or semi-private accommodation admitted to our public wards. We have a high percentage of public ward patients, as you can see.

THE CHAIRMAN: Yes, 55.

DR. SHARPE: This is for teaching purposes.

COMMISSIONER BALTZAN: Are you restricted in the number of private beds that you might have in your hospital?

DR. SHARPE: What do you mean, "restricted"?

COMMISSIONER BALTZAN: In numbers.

DR. SHARPE: We are restricted physically, yes. We are set up on the number of private, semi-private

clinical material since the hospitalization program came into force.

MR. SHAWNEE: No, sir. We have not

had that. We explain to the patients the purpose of it.

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high percentage of public ward patients, as you can see.

THE CHAIRMAN: Yes, sir.

MR. SHAWNEE: This is the situation.

COMMISSIONER BARTON: Are you satisfied-

ted in the number of private beds that you might have in

your hospital?

Yes?

COMMISSIONER BARTON: In numbers.

MR. SHAWNEE: We are restricted physically.

Yes, we are set up on the number of private, semi-private



Sharpe

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and public beds. The Hospital Commission has said there must be a certain percentage of private, semi-private and public. I think the figure is 50%. I don't know whether it has been adhered to or not.

THE CHAIRMAN: Yes, at least 50%.

DR. SHARPE: That is right.

THE CHAIRMAN: What about the use of the operating room, etcetera, on weekends?

DR. SHARPE: We use our operating room on Saturday morning. And the rest of Saturday it is used as emergency and urgency. Sunday kept pretty well emergency only. Our laboratory runs 24 hours a day seven days a week. So does our X-ray department. We try not to have a patient stay over that should be taken care of immediately.

COMMISSIONER VAN WART: Dr. Sharpe, in general terms, since the Hospitalization Insurance Act has come into force, has there been an increase in the chronic patients in your hospital as compared with before the Act came into force? Just in general terms.

DR. SHARPE: I don't think I can honestly answer that.

THE CHAIRMAN: If there has been an increase it has not been significant enough to ----

DR. SHARPE: That is right. I think this would have been brought to my attention. I don't think it is true --- we have taken off figures and we would say that on any day there are about 60 patients that should be moved out. In other words, we might be waiting for convalescent hospital, chronic beds or houses for



and public beds. The Hospital Commission has said there must be a certain percentage of private, semi-private and public. I think the figure is 50%. I don't know whether it has been adhered to or not.

THE CHAIRMAN: Yes, at least 50%.

THE CHAIRMAN: What about the use of

the operating room, etcetera, on weekends?

DR. SHAW: We use our operating room on Saturday morning. And the rest of Saturday it is used as emergency and surgery. Sunday kept pretty well empty, generally only. Our laboratory runs 24 hours a day seven days a week. So does our X-ray department. We try not to have a patient stay over that should be taken care of immediately.

COMMISSIONER VAN WART: Dr. Shaw, in general terms, since the Hospitalization Insurance Act has come into force, has there been an increase in the chronic patients in your hospital as compared with before the Act came into force, that is general terms.

Honorable answer that.

THE CHAIRMAN: It seems to me an

increase it has not been right in it enough to ---

DR. SHAW: What is right, I think this would have been brought to my attention. I don't think it is true -- we have taken off figures and we would say that on any day there are about 60 patients that should be moved out. On other weeks, we might be better. For convenience, hospital, chronic beds or houses for



Sharpe 12450

elderly people, nursing homes. In addition to that, we have this maybe 100 that we think could be in another type of facility, active prolonged treatment bed.

COMMISSIONER VAN WART: In other words, your chronic hospital problem has become a problem with the increase of acute cases coming into your hospital, crowding your accommodation?

DR. SHARPE: We always have a great number of acute patients. I think this is demonstrated by the large number of people we have from outside of this area. I think this is one of the reasons why this may not have changed too much.

THE CHAIRMAN: Thank you very much, Dr. Sharpe. I know that you are an extremely busy man, as are the other administrators who have come here today.

We are very grateful to you for taking the trouble to get the information from which you prepared this statement and for being of help to us.

DR. SHARPE: Thank you, sir, for inviting me to come.

THE SECRETARY: Mr. Chairman, the next submission is that of the Toronto Western Hospital to be presented by Mr. Wallace.

THE CHAIRMAN: Nice to see you again, Mr. Wallace.

MR. WALLACE: Thank you, sir. I consider it a privilege to come before you to give information and observations. Sister Janet was good enough to say in her prepared presentation to you the Toronto Western and St. Michael's are about the same size. They are 100 beds

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THE CHAIRMAN: Thank you very much.

Dr. Sharpe: I know that you are an extremely busy man, as are the other commissioners and have some other things to do. We are very grateful to you for taking

the trouble to get the information from which you prepared this statement and for being of help to us.

THE SECRETARY: Mr. Chairman, the next submission is that of the Toronto Western Hospital to be presented by Mr. Holmes.

THE CHAIRMAN: Nice to see you again.

MR. HOLMES: Thank you, sir. I consider it a privilege to come before you to give information and observations. Sister Tanner was good enough to say in his prepared presentation to you the Toronto Western and St. Michael's are about the same size. They are 100 beds



Wallace 12451

larger than we are. We are around 700 beds, they are over 800.

We have a building program going on and will have another 130 beds in about two or three or four weeks, so we are about the same size as they are.

We have about the same problems as St. Michael's have. We are half the size of Toronto General. That is one of the thermometers or yardsticks I use. I look at their figures and if mine are about half their size, I know I am all right.

COMMISSIONER McCUTCHEON: That is making a basic assumption, isn't it, Mr. Wallace?

MR. WALLACE: It is true. We have about 180 female patients on the waiting list at all times and about 120 male patients on the waiting list at all times.

The people on the waiting list, if they have to get in in two or three, four or five days, if they are willing to go on the standard ward, we can generally accommodate them, so we do not feel too badly. It is not too critical a situation although we would like to be in a better position to take care of the clientele more quickly than we do.

THE CHAIRMAN: The greater percentage of your demand is for private and semi-private accommodation?

MR. WALLACE: Yes.

THE CHAIRMAN: Is that from the location of the hospital? That you are not a downtown hospital?

MR. WALLACE: I don't know why that is.



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THE CHAIRMAN: Is that from the medical

of the hospital? What you are not a downtown hospital?



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I am sorry, but I cannot pinpoint why it is. I do know that practically everybody in Ontario is covered for standard. Well then, out of the 6,000,000 people there are over 2,000,000 people covered for at least semi-private by the Blue Cross, so there is that group of people who have said "Please, I would like to prepay something so that I might have semi-private."

THE CHAIRMAN: What is the proportion of private to semi-private?

MR. WALLACE: It's 51% private and semi-private and 49% public ward, within a few percentage points, because we have been building and opening odd little areas during the last two years and that percentage fluctuates from year to year. Within the last three or four or five years, it's very close to 50/50 in our hospital.

THE CHAIRMAN: Are you part of the teaching group as well?

MR. WALLACE: Yes, we are a teaching hospital and affiliated with the University. I would say we teach hardly 50% of the student members that are taught at the Toronto General. Hardly that number. We teach also dietitians and laboratory technicians and X-ray technicians and we have a teaching program in all those areas where the university comes to us and asks up please, would we permit teaching in our hospital.

THE CHAIRMAN: You have a nursing school as well?

MR. WALLACE: Yes. We have a nursing school of approximately 260 and we turn out about 80, 90



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Wallace 12453

graduate nurses each year.

I am obsessed with a little bit of an idea in connection with nursing schools. I feel that the Toronto General, St. Michael's, and the Western have about, between them, 3,000 beds where young ladies can be taught to be nurses. Now then, I feel that our Commission should not allow a hospital to go beyond 275, 325 beds and I think they should force them to have a nursing school, because the only place you can train young ladies to be nurses is where there are sick people.

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Now, on the periphery of Toronto there may be anywhere from 2,000 to 3,000 beds attached to smaller hospitals, to hospitals of sufficient size that they could support a nursing school, so maybe it is an obsession with me, but I feel that when they get to the size where they will attract 275 to 375 patients then they are in a community where they will attract young ladies to come there, because there is an awful lot of emotion, and loyalty, and glamour that gathers around a hospital. I now call out the names of the young ladies graduating, where 25 years ago I called out their mothers' names. So a hospital has a local loyalty, and I think that hospitals of that size should be forced to start and do their share, rather than parasiting those of us who are producing these nurses.

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THE CHAIRMAN: Do you actually think that would be an aid in recruitment?

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MR. WALLACE: I do. I think there is a glamour that grows up in a hospital, and a loyalty, and doctors' daughters, and people who have some connection with the hospital like to be identified with it.

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COMMISSIONER McCUTCHEON: You didn't keep those nurses very long 25 years ago?

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MR. WALLACE: Sir, they are awfully pretty and they are very attractive to young men, and that is what happens to us, and we may admit it.

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COMMISSIONER GIRARD: In thinking of a hospital having two or three hundred beds being the right place for a school, do you think also in the

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4 variety of experience, or only in the number of beds,
5 because that is very important in thinking of a school?

6 MR. WALLACE: Yes, I think of the
7 variety of experience, because there was a time in the
8 life of the Toronto Western Hospital when we were a 300,
9 400, and 500 bed hospital, and during that period of
10 our life we had a nursing school that was worthy and
11 excellent, and I think that that burden should be laid
12 on the shoulders of those hospitals when they come to
13 that size, that they should be asked not only to carry
14 their proportion of one kind of duty, but they should
15 carry the rest of their duties. Now, that may be an
16 obsession, but I feel strongly about it.

17 THE CHAIRMAN: Do you have some more
18 figures there?

19 MR. WALLACE: Only to say that in
20 thinking about the figures of the Toronto General and
21 St. Michael's, we have turning up at our emergency each
22 day people who must be admitted, people right out of a
23 clear sky that we have not had any prior knowledge of.
24 Sometimes as low as five in a day sometimes as high as
25 twelve in a day, and we take care of them. We do put
26 up beds on occasions, not in corridors, but in areas
27 adjacent to nursing stations, or in areas where they
28 should not be. We feel that is unfortunate, but it is
29 the way we have to live. I cannot remember when we have
30 turned anybody away. We have picked up the phone during
the night ourselves, and phoned St. Michael's or the
Toronto General or St. Joseph's and got help when we
were grossly overcrowded, and we don't like to be grossly
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4 into setting the beds up, and then taking them down,
5 and moving the patients.

6 THE CHAIRMAN: Have you got your length
7 of stay figures?

8 MR. WALLACE: Six or seven years ago
9 it was 12.3, and now it is 12.9. I would guess that it
10 goes up a tenth of a point per year. It might be
11 because of hospital insurance, or it might be because
12 of other reasons. I do know that we do have not as many
13 of these special areas as Toronto General, but we do
14 have cardiovascular areas, where heart cases are, they
15 are a long time ---

16 THE CHAIRMAN: I mean to say, we don't
17 question that. I mean, it is not something that has
18 to be established. We are looking for trend, and to
19 see if there are trends that have any meaning.

20 MR. WALLACE: The trend is to a longer
21 stay.

22 THE CHAIRMAN: Yes, but it is not a
23 very pronounced one?

24 MR. WALLACE: No, but I am quite aware
25 that doctors are subject to pressures by their patients
26 who say: "Please doctor, can't I stay another day?",
27 but I don't think that it is significant. I don't think
28 it is sufficiently great to be significant.

29 COMMISSIONER BALTZAN: Not to the
30 point where you would say that there are abuses on either
side?

MR. WALLACE: I don't think there are
abuses on either side. Our doctors, I would say, play



Wallace

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4 a pretty good game colleague-wise with each other. They
5 realize the importance of playing the game colleague-wise.

6 COMMISSIONER VAN WART: Your long
7 stay patients, in what departments are they chiefly?

8 MR. WALLACE: Well, let us say female
9 broken hips, cardiovascular ---

10 COMMISSIONER VAN WART: Those are
11 surgical cases ---

12 MR. WALLACE: Our obstetrical stay
13 is about seven days, depending upon circumstances. No,
14 there are also long stay medical cases as well. We think
15 that we have in our hospitals about 35 cases at any day
16 that could be moved somewhere else, but it takes a long
17 time to fill out the papers and find their relatives,
18 and there is all that ceremony to go through, which I
19 am satisfied you must go through, whereas if you could
20 just bodily pick the patient up and say: "You are going
21 to that hospital tonight", you could ---

22 COMMISSIONER VAN WART: Do you have
23 psychiatric long stay?

24 MR. WALLACE: We have. We have a
25 psychiatric unit of 33 beds. Theoretically it is not
26 for long stay patients, but on occasions there are long
27 stay psychiatric patients.

28 COMMISSIONER VAN WART: And they run
29 your per diem up?

30 MR. WALLACE: Yes.

COMMISSIONER VAN WART: Has that service
been increased?

MR. WALLACE: Sir, it is limited to
33 beds. It could increase if we had the beds, but it is



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full all the time. There is pressure on all the time.

COMMISSIONER VAN WART: How long have you had 33 beds available?

MR. WALLACE: Since about February of 1952.

THE CHAIRMAN: Are you able to give us any percentage of your population on a given day, any day that you may have chosen, who might be accommodated elsewhere, who do not necessarily have to be in the acute general hospital?

MR. WALLACE: There is about 35 to 50 in any one day, that if we could arbitrarily march in and say: "Come with us, you are going to another place", we think we could take somewhere around 35 or 40 or 50. It varies when you check from day to day. You get 35 when you check one day and 50 when you check another day, but somewhere in that nature.

I am of the opinion that it is difficult to pick those people up and transport them 10, 12 or 15 miles to some other place. I think that it might be a wise idea if hospitals such as ours had a place where you could pick those people up quickly and move them to less costly accommodation.

THE CHAIRMAN: You mean adjoining, or nearby?

MR. WALLACE: Yes, because the patients themselves do not like to leave their doctors ---

THE CHAIRMAN: So that in case of necessity they may come back quickly?

MR. WALLACE: Yes, that is very true.



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4 THE CHAIRMAN: Would you have that
5 type of hospital, or accommodation, under the same
6 management, that type of accommodation?

7 MR. WALLACE: Well, I would say yes.

8 THE CHAIRMAN: We have had both
9 opinions here and there, opinions both ways on that.

10 MR. WALLACE: I would say yes. But
11 you see, our Board of Governors have never felt free to
12 use the money which they obtained to put that in, because
13 there has been greater pressures to put in the more
14 critical beds.

15 THE CHAIRMAN: What about the use of
16 your operating room facilities on weekends?

17 MR. WALLACE: We run up until noon,
18 twelve o'clock. We try not to go past twelve o'clock
19 on Saturdays. On occasions we have to, but from twelve
20 o'clock on and all day Sunday the operating rooms are
21 only used for emergency and things which are not planned.
22 We have a staff on.

23 One of the reasons we do that is
24 because we try to have our employees live as normal a
25 life as they can with their loved ones and their friends
26 and acquaintances. If we impose too much of an abnormal
27 life on an employee, then pretty soon he begins to get
28 annoyed and looks for another job.

29 COMMISSIONER BALTZAN: May I say that
30 I respect very much your personal convictions, and I
don't call them obsessions. Along that line, what is
your conviction, or belief in what is an ideal size for
a hospital? You said 300?



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MR. WALLACE: Well no, an ideal size for a hospital ---

COMMISSIONER BALTZAN: There is that figure in my mind.

MR. WALLACE: I was told 20 years ago it was 500 beds. I was told ten years ago it was 700 beds. A few years ago I was told it was 800 beds. I am convinced that a teaching hospital, that every nine or ten years circumstances over which they have no control force them to expand, and I would hate to see the Toronto Western Hospital have more than a thousand beds, because eight hundred beds is about my mental capacity to handle.

COMMISSIONER BALTZAN: Does it become more uneconomical?

MR. WALLACE: No I don't think it is any more uneconomical. I think maybe it might be more economical the larger it got, but just as you measure the problems that hospital people have, I just cannot understand how Dr. Sharpe looks so well and is so healthy.

THE CHAIRMAN: Thank you again Mr. Wallace. We are deeply obliged to you.

MR. WALLACE: Thank you sir, I consider it a privilege.

THE SECRETARY: The next submission, Mr. Chairman, is from the Northwestern General Hospital, and Mr. Cowan will come forward and present this submission.

---EXHIBIT NO. 373: Submission of the Northwestern General Hospital.



12461

SUBMISSION OF
NORTHWESTERN GENERAL HOSPITAL

APPEARANCES: Mr. R.B. Cowan
Mr. Frank Seymour

THE CHAIRMAN: I want to thank you
before you begin for having accepted the invitation.

MR. COWAN: I would like to thank you
for the opportunity of presenting some ideas we have at
the Northwestern General Hospital on the question of
student nurses. Inasmuch as we submitted 25 copies of
this brief in April, is it satisfactory to you if I simply
read the summary?

THE CHAIRMAN: Oh yes, if you will,
and then any comments and additions as you may wish, and
you might have in mind the discussion you have heard this
afternoon. If you want to add anything to it we would
be very glad to have your views and observations.

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4 MR. COWAN: 27. The all-pervading
5 problem in Canada today of the shortage of nurses to
6 meet the health needs of the Nation demands immediate
7 and positive action. The number of graduate nurses
8 now being registered each year is so far short of the
9 requirements of the Country - it is recommended that
10 new schools of nursing be established at once making
11 use of the Department of Veterans' Affairs Hospitals
12 already in existence, for the clinical experience
13 necessary.

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15 28. Since hospital residences for
16 student nurses are costly to build and require one or
17 two years for construction, it is recommended that a
18 day school plan of education for student nurses be
19 introduced immediately, thus ensuring the graduation of
20 competent nurses within a minimum of time.

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22 29. Since enquiries and investigations
23 over the years have shown that the calibre of instruc-
24 tresses in presently established schools of nursing is
25 not uniformly high across the nation, it is recommended
26 that the Canadian Government engage a cadre of top-
27 ranking nursing instructresses who would travel to a
28 large number of Department of Veterans' Affairs
29 Hospitals, thus giving top level instruction to all
30 student nurses throughout their courses. By adopting
this recommendation of a "travelling faculty" the
Canadian Government would do much to make certain that
the greatest possible number of student nurses in the
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Students would not be faced with the possibility of



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problem in Canada today of the shortage of nurses to meet the health needs of the nation demands immediate and positive action. The number of graduate nurses now being registered each year is so far short of the requirements of the country - it is recommended that new schools of nursing be established at once making use of the Department of Veterans' Affairs Hospitals already in existence, for the clinical experience

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over the years have shown that the calibre of instruction in presently established schools of nursing is not uniformly high across the nation, it is recommended that the Canadian Government engage a cadre of top-ranking nursing instructors who would travel to a large number of Department of Veterans' Affairs Hospitals, thus giving top level instruction to all student nurses throughout their courses. By adopting this recommendation of a travelling faculty, the Canadian Government would do much to make certain that the greatest possible number of student nurses in the new schools would pass their registration examinations. Students would not be faced with the possibility of



Cowan

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failing their examinations because of poor teaching by local instructresses.

30. It is recommended that the Federal system of University Grants be so operated that money from that educational source would be made available for the inauguration of these new schools for nurses, with such money also being made available for future operation. It is further recommended that the Canadian Government's system of grants for Vocational Education should be broadened to cover grants for future schools of nursing associated with hospitals now operated by the Canadian Government.

That, in four paragraphs, is the summation of the thoughts advanced in the brief that has been prepared in regard to the inauguration of day schools of nursing in Canada.

You were kind enough to say I might comment on comments heard earlier this afternoon. Sister Janet at St. Michael's Hospital was asked where she would get the necessary staff if the hospital was larger, and I noticed in this morning's Globe and Mail that they are going to have trouble to staff the new 900-bed Riverdale Hospital.

Quite a few references were made to that hospital today. It would mean overcrowding the Toronto hospitals, and here we have, at the meeting yesterday, the comment that they are going to have trouble getting the staff to handle the hospital, that they do not have staff to handle the patients coming in. They are going to be short about 150 nurses at Riverdale



Cowan

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Hospital and another 40 to staff the new Scarborough Home for the Aged.

At the Northwestern General Hospital we sent one of our trustees over to England and Scotland in the month of January in an endeavour to secure nurses, because at that time, we had a floor-and-a-half of the new floor addition locked up because we didn't have the people to handle the work. We know that the Burlington Hospital on the outskirts of Hamilton and we know that the Hamilton hospitals are having difficulty in recruiting nurses. We know that the Canadian Government should make use of the facilities available for new nursing schools. We favour a 2-year nursing education course along the lines of the Toronto Western Hospital.

I wish to make the further recommendation in connection with these nursing schools at the D.V.A. hospitals, that, instead of having the officials of these new schools of nursing spend their time, shall I say, seeking out young girls from 17 to 20 years of age leaving the secondary schools to enter the nursing schools, that a great effort should be made to attract into the nursing profession those married women roughly of an age from 35 to 42 who can be best classified by stating that the youngest child in their family has now entered school and they don't have the responsibility of looking after the little ones running around the home with everybody in school.

The women from that age group, 35 to 42, I do believe, could be - I don't want to use the



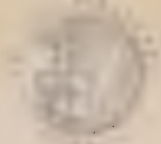
Cowan

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4 word inveigled - could be enticed or attracted into
5 the nursing profession, and it would give a worthwhile
6 work to an age group of people, many of whom have the
7 idea that once they have attained the age of 40, nobody
8 wants to make use of them.

9 I know hospitals in Ontario where 90%
10 of the nursing staff are married women; the overall
11 average in Ontario is 30%, and I do believe there is a
12 great untouched pool of possible nurses in that age
13 group of married women from 35 to 42 whose children
14 are all in school. With a day school system of nursing
15 they could go up to the hospitals and be trained and
16 return home at 5 o'clock in the evening or 4 o'clock
17 in the afternoon. The same with girls studying to be
18 lawyers and architects. These same girls could look
19 after their families in the evening, at the weekend,
20 meals; there is no difficulty with accommodation, they
21 have their own accommodation at home, and I do feel
22 that all across the country a definite approach should
23 be made to that age group.

24 I have heard considerably today, as I
25 have heard for the last several years, of the shortage
26 of hospital beds, shortage of hospital beds, shortage
27 of hospital beds, and I can only repeat what I said
28 first in 1960, that there is a tremendous amount of
29 hospital beds available in heavily-populated parts of
30 Canada if they would turn hospital nurses' resident beds
and tell them to go and live the same as other young
ladies who are seeking education, say, in the field of
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word implied - could be enlisted or attracted into the nursing profession, and it would give a worthwhile work to an age group of people, many of whom have the idea that once they have attained the age of 40, nobody wants to make use of them.

I know hospitals in Ontario where 80% of the nursing staff are married women; the overall average in Ontario is 30%, and I do believe there is a great untapped pool of possible nurses in that age group of married women from 35 to 42 whose children are all in school. With a day school system of nursing they could go up to the hospitals and be trained and return home at 5 o'clock in the evening or 4 o'clock in the afternoon. The same with girls studying to be lawyers and architects. These same girls could look after their families in the evening, at the weekend, meals; there is no difficulty with accommodation, they have their own accommodation at home, and I do feel that all across the country a definite approach should be made to that age group.

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open to women is the demand made that you must sleep on the job. It seems a girl can be a lawyer without sleeping at law school, a girl can be an architect without sleeping at engineering, and so on. But there seems to be some kind of a conviction that a girl can't be a nurse unless she sleeps on the job.

I feel that the shortage of hospital beds in Toronto could easily be solved if an intelligent approach was made to the question even along that line.

In the recommendation that the North-western Hospital has advanced here in training schools, we point out that any new school for nursing should get away from that in-service idea.

I noticed one person said here that this figure includes the student nurses, and yet I have been at hospital meetings where student nurses are not considered part of the staff, and I am not convinced that their costs per day can be compared because of that. I think any sensible person realizes that nurses are considered staff by 98% of the hospitals. You have schools of nurses, whether or not the hospital admits that or not.

THE CHAIRMAN: I suppose we were not committing ourselves to refinements on staff at that stage. It wasn't part of our discussion at the moment.

MR. COWAN: Mr. Chairman, the North-western General Hospital is eminently satisfied with the Ontario Hospital Services Commission. We think it is doing a very, very difficult job and doing it well, but when they start to talk to us about the day labour costs



Cowan

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4 at our hospital, where we have no school of nursing,
5 we ask if it is fair to take a hospital where we pay
6 full wages to everyone on the staff and compare it
7 with a hospital which has a large number of student
8 nurses in their school, and we get rather evasive
9 answers. We feel our day labour costs are quite high,
10 but when we ask to compare them with hospitals who have
11 schools of nursing, we do become a little concerned
12 with what we consider an unfair comparison.

13 THE CHAIRMAN: Did you ever have the
14 sort of financial responsibility for a hospital that
15 did have a nursing school? Did you ever have experience
16 in that regard?

17 MR. COWAN: No, I never have.

18 THE CHAIRMAN: So there may be another
19 side of the coin.

20 MR. COWAN: I am quite willing to
21 admit that, but I sincerely hope I don't have that
22 experience, a hospital with a school of nursing.

23 THE CHAIRMAN: You just complain
24 about the lack of nurses and leave it to the other
25 hospitals. You say that the Government should train
26 nurses in the D.V.A. hospitals and Toronto General
27 should train and St. Michael's should train, but not
28 your hospital.

29 MR. COWAN: I don't think hospitals
30 should train nurses whatsoever. I think it should be
under the Department of Education, and I think they
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and under the Departments of Education of the various



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Cowan

12468

provinces.

THE CHAIRMAN: That is a view you are entitled to, and you are not alone in it, but whether you are a majority in it is another story.

You speak, and I think perhaps you have stressed, the shortage of nurses, accented perhaps more than anyone else we have heard, and yet we have been told, and these are the official figures, that the ratio of nurses to population in Canana is just about as good as any part of the world and that in Ontario, with the exception of British Columbia, it is perhaps as good as it is in North America, one nurse for approximately 203 to 204 population. If you are going to England to get nurses where the nursing figure isn't any better, perhaps worse ---

MR. COWAN: I have seen those comparisons, sir, and I rather regret that in such a fine province as Ontario we are asked to be satisfied with the average of other nations when there is a better possible figure to be obtained.

Now, in the body of the brief I have pointed out that in making preparation for this presentation, I secured, from the Department of Veterans' Affairs in Ottawa, figures to show the shortage of nurses, 11.2% for the month of February, 1962. Those were the latest available to me at the beginning of April. In that month, 5,171 registered nurses were on the payroll of the Department.

THE CHAIRMAN: A few days ago there was a group in here who told us they were closing beds



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Cowan

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4 in Sunnybrook because there were no nurses, and the
5 very next day we had a denial of that from the administra-
6 tor; he said it wasn't so. You take your money and you
7 take your choice.

8 MR. COWAN: I noticed the comment of
9 the assistant administrator. He said that no veterans
10 who required hospital accommodation had been refused.
11 These shortages are listed individually right across
12 the country, and it shows a shortage at Sunnybrook, of
13 nurses, from the pre-determined establishment, and the
14 shortage was 11.2%.

15 THE CHAIRMAN: Parkinson's Law works
16 well in these government establishments, as you know.
17 It is just a matter of organizational establishment.

18 MR. COWAN: Yes, sir. I would like to
19 make the suggestion, sir, that you have briefs which I
20 read in Ottawa from a large number of very qualified
21 commentators saying that 21% of the trained nurses
22 ultimately stayed in the profession and the remainder
23 are lost to the profession in a short period of time.

24 I believe that we could increase the
25 number of married nurses in the hospitals in the country
26 if we were to make the wages attractive to them, and I
27 sincerely believe - I have been all my life in the
28 printing trades, my father before me - I sincerely
29 believe that if the differential rate of pay were intro-
30 duced by the hospital service, whereby people are paid
different rates of pay for nights and for working on
statutory holidays, for working on Sundays, the same
rate as they have been paying for so many years in the



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Cowan 12470

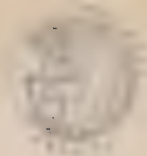
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OWAN

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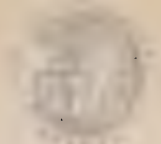
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There are a large number of hospitals today that ease up in their operations over the weekend because they cannot get the staff to work that sixth and seventh day. In the Summer months the nurses, in particular, like to go on holidays the same as everyone else, and I am confident, and so are my fellow trustees, that if we had a differential scale for hospitals whereby they got paid for their night work, their sixth day work, Sunday work and statutory holidays, that many qualified nurses would be attracted back into the profession in order to pick up money that would then be available to them. You would find that the hospitals would be able to render more services to the community than they render today, because they would be fully staffed at all times.

I presume, sir, that you are well aware of what the Notre Dame Hospital --- the Winnipeg General Hospital did in Winnipeg where some years ago they built this limited dividend housing and made the accommodation available to qualified nurses, that they might come and live in the apartments, bring their mothers or fathers or brothers and sisters, but they had to sign an agreement upon moving into this dividend housing built on the grounds of the hospital that they would work on the hospital staff.

When we approached the Federal Government for the same kind of help, we were advised that the regulations had been altered after the Winnipeg proposition, as the major idea in the scheme had not been to aid hospitals or special groups, but to aid the community as a whole. I cite that as a case to show you where one



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Cowan

12472

hospital made an intelligent approach to bring back into the nursing stream married women. I congratulate the Winnipeg Hospital for having evolved the idea, because it gave them a great aid and help in staffing their hospital.

I do feel a more direct approach could be made to these married, qualified nurses, particularly if there is an attractive wage scale for them. We do not pay our night side printers the same as the day side printers. We don't pay the man who works the sixth day the same.

THE CHAIRMAN: I think we are aware of the situation. Are you in a position to deal with some questions, specific questions about occupancy and that kind of thing?

MR. COWAN: That is why I brought the administrator.

THE CHAIRMAN: Mr. Seymour, these questions we have been concerning ourselves with earlier in the afternoon, have you figures or do you wish to deal with the thing piecemeal? Have you a statement you would like to make?

MR. SEYMOUR: I brought no figures with me. In fact, I was just invited to come down this morning. I have no figures with me, but I will attempt to answer anything you care to ask.

THE CHAIRMAN: We will try to ask something relevant. Mr. McCutcheon draws to my attention you are not one of the group that was invited. I overlook that at the moment. In a general way, in this matter of

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Seymour

alternative accommodation for long stay convalescent and so forth, aged patients, have you any views to express on that in terms of the population in your hospital and how many might otherwise be accommodated and under what circumstances?

MR. SEYMOUR: We always have delay in moving patients that should be in chronic and nursing homes. There is always delay in getting them out, from one or two weeks up to as much as a month or so. If the movement out of the hospital could be expedited it would free other beds for us.

THE CHAIRMAN: Would you care to give an estimate? We have two estimates, two or three, 9%, 10% and the last one was in the neighbourhood of 5.

MR. SEYMOUR: An estimate of the number of beds?

THE CHAIRMAN: If alternate accommodation was available, people could leave the hospital this afternoon, or on any given day.

MR. SEYMOUR: Well, the other day I was aware of three. We are a smaller hospital looking after around 175 patients at the moment. The other day there were three we were trying to move. As to the situation today, I don't know, but there were three we had we were trying to get out.

THE CHAIRMAN: You haven't a significant number at any event?

MR. SEYMOUR: There is always one or two we are trying to move.

THE CHAIRMAN: What about use of your



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THE CHAIRMAN: You haven't a significant number at any event? MR. SEYMOUR: There is always one or two we are trying to move. THE CHAIRMAN: What about use of your



Seymour 12474

accommodation, of your operating room accommodation?
Are you restricted to five days a week or anything like that?

MR. SEYMOUR: Up until recently we were able to keep operating on Saturday, there was a sixth day.

THE CHAIRMAN: Until noon.

MR. SEYMOUR: Recently we had to cut back.. We only do emergency work on Saturday with the exception, maybe, of two or three minor elective procedures that wouldn't be too burdensome on the staff that would be there for emergency work.

THE CHAIRMAN: I appreciate you haven't had the opportunity to give consideration to this question, but if you could be of any help to us on the utilization of hospital beds for diagnostic purposes, people in hospital who are there for diagnostic purposes, but who might be taken care of in the clinics or out-patient departments and so leave the bed for the acutely ill person, we would appreciate it?

MR. SEYMOUR: There again, if a patient came in for purely diagnostic work, and there is no treatment given, they are not going to be covered under the terms of the Ontario Hospital Services Commission.

THE CHAIRMAN: They are always admitted under some form of diagnosis.

MR. SEYMOUR: That is true, but I believe very little of that goes on with us. There is a constant demand for the beds and the medical staff through the medium of their rounds and their pressure for beds,

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Seymour 12475

I think, police it fairly well. I wouldn't say it doesn't happen in our institution.

THE CHAIRMAN: We can appreciate that. I am talking about something significant. Have you noticed anything of significance in the length of stay in the period since hospitalization came into effect in Ontario, since the hospitalization program came into effect in Ontario?

MR. SEYMOUR: Our length of stay is fairly static at around six days.

THE CHAIRMAN: That is maternity?

MR. SEYMOUR: That is overall.

THE CHAIRMAN: That is quite a remarkable figure.

MR. SEYMOUR: Our maternity stay is five days.

THE CHAIRMAN: You are almost as good as Newfoundland.

MR. SEYMOUR: We, of course, don't do the cardiovascular and neurosurgical work or the extensive work done in the downtown hospitals. That figure has worked up these last few months to about seven days and we have been doing some inquiring as to that, the reason for that.

THE CHAIRMAN: That figure at six-something or even seven for a non-teaching hospital is to my recollection at the moment below the national average by some points.

MR. SEYMOUR: Yes, sir.

THE CHAIRMAN: What is the answer?

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MR. SEYMOUR: Yes, sir.

THE CHAIRMAN: What is the answer?



Seymour

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Maybe some of the other hospitals would like to know.

MR. SEYMOUR: There is the matter of work done. We don't do the range of work that the downtown hospitals do. We have a very large medical staff. We have 104 doctors, so there is a constant pressure for beds and I believe that is the main. We do have admitting and discharge committees that review admissions and review the length of stay, but I think that the main pressure to remove patients rapidly comes from the medical staff itself.

THE CHAIRMAN: Have you alternate accommodation available that you can look to?

MR. SEYMOUR: I am sorry, alternative accommodation?

THE CHAIRMAN: Accommodation for a patient that is ready to leave acute hospital, but perhaps, not ready to go home. Have you got some place you are able to say, well now, we have a prior right to put our patients there.

MR. SEYMOUR: No, we have no prior right. We try to get them to the convalescent hospitals or the nursing homes that are available.

COMMISSIONER VAN WART: Do you move many acute cases and other procedures to other hospitals in town?

MR. SEYMOUR: That would be prior to admission?

COMMISSIONER VAN WART: Patients admitted in hospital and then transferred?

MR. SEYMOUR: After treatment, no, very few.

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Seymour 12477

COMMISSIONER VAN WART: Very few.

I had in mind you might have them four or five days and then they go down to other hospitals.

COMMISSIONER McCUTCHEON: What kind of waiting list have you got?

MR. SEYMOUR: A waiting list of around 50. It would vary from one month to two months waiting time. The medical patients are the slowest moving, and some of our men have said they don't get an elective medical patient into our hospital, the only ones that get in are emergency ones in the medical department.

THE CHAIRMAN: You operate an emergency department, of course.

MR. SEYMOUR: Yes.

THE CHAIRMAN: But not out-patient.

MR. SEYMOUR: We have an organized out-patient department. We are the only non-teaching hospital, I believe, in Ontario that has such a department.

THE CHAIRMAN: What is the volume?

MR. SEYMOUR: Around 4,000, 4200 visits a year in the out-patients.

THE CHAIRMAN: Ten or twelve a day.

MR. COWAN: Northwestern General Hospital opened with 104 beds, but the men and women who started that hospital were more interested in out-patient than in in-patient and for the past seven years we were the smallest hospital in Ontario with an out-patient department, in which, we took a great deal of satisfaction.

THE CHAIRMAN: You must forgive me if I do not know just where the hospital is located. Is it



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contiguous to an industrial or a residential area?

MR. COWAN: I would say the way they are building apartments around us it is a residential area. It is on the north-western outskirts of the city and it was largely a residential area when we started to build in the early 1950's. The Township of North York zoned the large area up there as commercial and light industrial, so we border on a light industrial and commercial area, but the Township of York --- we are right on the boundary --- has zoned their area as residential.

THE CHAIRMAN: I was wondering if there was any demand from the fact that you are contiguous to industry for this out-patient department.

MR. COWAN: No, it was the desire of the people who started the hospital to have an out-patient department.

THE CHAIRMAN: For the residential area.

MR. COWAN: For the residential area of the Township of York. We see a great need for it. At the present time we have finished the fourth floor addition.

THE CHAIRMAN: Do you think the fact you operate an out-patient department and operate it quite efficiently, I take it, has any bearing on your length of stay, on admissions and that kind of thing?

MR. SEYMOUR: I wouldn't think so.

COMMISSIONER BALTZAN: Is that a so-called free service that you are giving in the out-patients?



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Is that based along the lines of larger and older setups with out-patient services?

MR. COWAN: Exactly, sir. It costs the hospital about \$20,000.00 a year for its services, not covered by O.H.S.C., and which we cover in what is known as a differential under the O.H.S.C. setup.



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COMMISSIONER BALTZAN: It is not just an emergency?

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MR. COWAN: No sir.

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COMMISSIONER BALTZAN: Includes diagnostic and therapeutic?

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MR. COWAN: Yes sir.

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THE CHAIRMAN: Your bed situation is roughly 50% public accommodation, ward accommodation and ---

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MR. COWAN: We do not have any private at all sir. If people come to our hospital and want private accommodation, depending on the crush of beds, which is continuous, we will remove the second bed from a room and call it private but we do not have -- I think we have four rooms with a single bed in them but we have no private accommodation.

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THE CHAIRMAN: And you find that that is acceptable?

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MR. COWAN: The way they want beds, they do not complain.

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COMMISSIONER McCUTCHEON: Where do you get the differential?

DR. COWAN: The differential is the semi-private rate, you see, would be about \$4.00 a day and then if we take the second bed out of the room to give a person private accommodation, there is a \$7.00 a day differential.

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COMMISSIONER McCUTCHEON: You have a large number of semi-private beds?

MR. COWAN: Yes, a fair number.

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4 COMMISSIONER McCUTCHEON: What
5 proportion? Have you any idea?

6 MR. SEYMOUR: It would be around 40%.
7 We have about 60% standard.

8 THE CHAIRMAN: I should know this, but
9 under the Ontario system do you retain the whole of the
10 differential or half?

11 MR. COWAN: Only one-half. I wish to
12 point out, Mr. Seymour pointed out we have 175 beds and
13 107 doctors. We have completed a four floor addition
14 and we have the beds to handle 250 accommodation and
15 if we had the staff to do it, we would have them now
16 because our building is finished and equipment all in.

17 COMMISSIONER BALTZAN: By staff do
18 you mean -- not just medical staff?

19 MR. COWAN: No. We have no shortage
20 of medical staff sir.

21 THE CHAIRMAN: You mean nurses and
22 technicians?

23 MR. COWAN: That is right. Some
24 doctors on the medical staff think that we are over-
25 staffed.

26 THE CHAIRMAN: When you say a shortage
27 of nurses, you mean it?

28 MR. COWAN: We mean it. We are talking
29 from factual experience, not from theoretical reading.

30 THE CHAIRMAN: Thank you very much
Mr. Cowan. I know you are a very busy man and we are
very pleased that you were able to come and we want to
thank you for taking the trouble to prepare a brief and



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3 because you have an idea, so far as personnel is concerned
4 and health services, this is the place we want to hear
5 it and we are glad to have heard it.

6 MR. COWAN: I think this is the place
7 to present it. Thank you.

8 THE CHAIRMAN: We will adjourn now
9 until nine o'clock tomorrow morning.

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11 ---ADJOURNMENT.
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